

00-03485

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

11641

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Gertrude F. Algard								April 12, 1986								11:36 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 73 HRS		MONTHS		DAYS		HOURS	
Female		White		April 23, 1903		82 yrs.		YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Delaware		USA				Harford											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Darlington		4303 Conowingo Road		Housewife													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Harford		Harford		Grady		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1024 Chesapeake Drive		21078					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Harry C. Blest		Elizabeth S. Denny															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		221-12-8839		Carroll E. Algard		Harford E. Algard, Md.		21078		1024 Chesapeake Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				Renal failure		Accvd								2 wk.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
Alzheimer's d.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from		19 85 to 4 11 19 86, that (I) (we) last		saw the deceased alive on 3/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		8/13/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Randall Cronin		721 Wheeler School Rd Whiteford, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Cremation		4/14/86		R.A. Ferris & Co.		West Chester		Chester		Pa.							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Lee A. Patterson		Perryville, Md.		APR 14 1986													

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-084-02

20% COTTON FIBER

WILKINSON



11/15/84

00-03750

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11642

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR		P		M	
NELLIE		MAY		BECHTOLD				Apr. 13		19		86						10:30		P		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED		10. DATE OF DEATH		11. DATE OF DEATH		12. HOUR		13. P		14. M	
Female		White		Feb. 2, 1904		82 YRS.						April 14, 1986						2:30		P		M	
15a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		15b. CITIZEN OF WHAT COUNTRY?		16. MARRIED		17. NEVER MARRIED		18. WIDOWED		19. DIVORCED		20. BALTIMORE CITY OR COUNTY OF DEATH		21. Harford County		22. MD.							
Maryland		USA										Harford County											
23. CITY OR TOWN OF DEATH		24. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		25. USUAL OCCUPATION (TYPE OF WORK)		26. KIND OF BUSINESS OR INDUSTRY		27. Havre de Grace		28. 106 Hopkins Road		29. Homemaker		30. Harford County		31. 21078		32. Harford County		33. 21078		34. Harford County	
23a. STATE		23b. COUNTY		23c. CITY OR TOWN		23d. INSIDE CITY LIMITS?		23e. STREET ADDRESS		23f. 106 Hopkins Road		23g. 21078		23h. Harford County		23i. 21078		23j. Harford County		23k. 21078		23l. Harford County	
23a. Maryland		23b. Harford		23c. Havre de Grace		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23e. 106 Hopkins Road		23f. 21078		23g. Harford County		23h. 21078		23i. Harford County		23j. 21078		23k. Harford County		23l. 21078	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. INFORMANT		17. ADDRESS		18. Charles		19. William		20. Campbell		21. Ada		22. Ruth		23. Campbell		24. Clarissa B. Rose		25. 106 Hopkins Road	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES?		14b. SOCIAL SECURITY NO.		14c. 218-14-0681		14d. 106 Hopkins Road		14e. 21078		14f. Harford County		14g. 21078		14h. Harford County		14i. 21078		14j. Harford County		14k. 21078		14l. Harford County	
14a. No		14b. 218-14-0681		14c. 106 Hopkins Road		14d. 21078		14e. Harford County		14f. 21078		14g. Harford County		14h. 21078		14i. Harford County		14j. 21078		14k. Harford County		14l. 21078	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. PART I DEATH WAS CAUSED BY:		21. IMMEDIATE CAUSE (a)		22. Coronary Heart Disease		23. DUE TO, OR AS A CONSEQUENCE OF		24. (b) A. S. C. V. D.		25. DUE TO, OR AS A CONSEQUENCE OF		26. (c)		27. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		28. (b)		29. (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		20. AUTOPSY?		21. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED?		24. 21a. EXTERNAL CAUSE WAS		25. 21b. TIME OF INJURY		26. 21c. HOW INJURY OCCURRED		27. 21d. INJURY OCCURRED		28. 21e. PLACE OF INJURY		29. 21f. LOCATION		30. 21g. LOCATION	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION		21h. LOCATION		21i. LOCATION		21j. LOCATION		21k. LOCATION		21l. LOCATION	
21a. UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. HOUR A.M. MONTH DAY YEAR		21c. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		21d. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. STREET		21g. CITY OR TOWN		21h. COUNTY		21i. STATE		21j. STATE		21k. STATE		21l. STATE	
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22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
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22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide <input type="checkbox"/>		22j. Homicide <input type="checkbox"/>		22k. Undetermined manner <input type="checkbox"/>		22l. Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/>		22c. Inspection <input checked="" type="checkbox"/>		22d. Inquiry <input type="checkbox"/>		22e. and in my opinion		22f. death resulted from:		22g. Natural causes <input checked="" type="checkbox"/>		22h. Accident <input type="checkbox"/>		22i. Suicide							

00-04748

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611643
REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MAZIE E. BLEVINS			2a DATE OF DEATH MONTH DAY YEAR 4-21 86		2b HOUR 11:20 A.M.
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10 CITY OR TOWN OF DEATH FALLSTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland			13b COUNTY Harford	13c CITY OR TOWN Jarrettsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Franklin W. Perry			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zylpha Perish		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-14-5387		17 INFORMANT ADDRESS Hazel Brinegar Bel Air, Md.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) End stage C.M.		
DUE TO, OR AS A CONSEQUENCE OF (c) Cold D. C.M.		

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE 2112 Bel Air Road Bel Air, Md.	
22a I certify that (I) (this hospital) attended the deceased from 4/17 19 86 to 4/21 19 86 that (I) (we) last saw the deceased alive on 4/21 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death.			
22b SIGNATURE M. S. N. R.		22c DATE SIGNED 4/21/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. S. N. R.		22e ADDRESS 2112 Bel Air Road Bel Air, Md.	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 4/23/1986	23c NAME OF CEMETERY OR CREMATORY Jarrettsville Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Jarrettsville, Harford, Md.
24 FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.		25a DATE REC'D. BY REGISTRAR APR 24 1986	25b REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JAN 17 1964
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

[Large circular stamp, likely a "RECEIVED" or "FILED" stamp, with illegible text inside.]

[Faint, illegible text and markings, possibly a signature or additional stamp.]

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JAN 17 1964
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

00-03747

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611644
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RHODA E. BOWMAN			2a. DATE OF DEATH MONTH 4 DAY 15 YEAR 86		2b. HOUR 9 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH SEPTEMBER DAY 28 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1414 CHAPEL ROAD 21078
14. FATHER'S NAME FIRST ISSAC MIDDLE LAST QUESINBERRY		15. MOTHER'S MAIDEN NAME FIRST ARLENE MIDDLE LAST HAWKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 26 7017		17. INFORMANT ADDRESS MRS. BERNICE BALDWIN 1745 BRYAN ROAD HAVRE de GRACE 21078	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Anticoagulant</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>85</u> to <u>4/15</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>4/15</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.			
22b. SIGNATURE <u>Dante Monakile</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>4/15/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKILE		22e. ADDRESS HAVRE de GRACE, MD 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 18 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY BOWMAN FAMILY PLOT	23d. LOCATION CITY OR TOWN COUNTY STATE HILLVILLE, CARROLL CO., VIRGINIA
24. FUNERAL DIRECTOR NAME MOODY FUNERAL HOME MT. AIRY, N.C. 27030 MITCHELL FUNERAL HOME, PA HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR APR 16 1986	25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
referred by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-04209

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEWIS Edward Catron			2a. DATE OF DEATH MONTH 4 DAY 17 YEAR 86		2b. HOUR 4 52 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH June DAY 25 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Smith Co Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Worker		12b. KIND OF BUSINESS OR INDUSTRY Shoe
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 113 Sturgill Drive 21014	
14. FATHER'S NAME FIRST Lonis MIDDLE Robert LAST Catron		15. MOTHER'S MAIDEN NAME FIRST Susia MIDDLE Victoria LAST Atwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 226-30-3971		17. INFORMANT ADDRESS Md. 21904 Claude Atwell, 12 Central Drive, Port Deposit	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) OPR CARCINOMA of LUNG 8 mos DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 4/17/86 to 4/17/86 , that (I) (we) last saw the deceased alive on 4/17/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Edwards		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. EDWARDS		22e. ADDRESS 2112 BELAIR RD FALLSTON, MARYLAND 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Apr. 19, 1986	23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR APR 21 1986		
25b. REGISTRAR'S SIGNATURE Jane Davidson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal certificate must be notified of.

00-1150



0-03936

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 4 6
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST JAMES		MIDDLE EDWIN		LAST CAULFORD		2a. DATE OF DEATH		MONTH April		DAY 12		YEAR 1986		2b. HOUR 6 ²⁵ P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH		MONTH 12		DAY 11		YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 1 YEAR DAYS		IF UNDER 1 YEAR HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.													
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Hartford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Civil Service													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)		13a. STATE Md.		13b. COUNTY Hartford		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3111 Queens Castle Cr. / 21154									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-10-2080		17. INFORMANT Elizabeth W. Caulford		ADDRESS 3111 Queens Castle Ct. Street Md 21154									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hour																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)																	
		DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a COPD, Severe																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 4/10/86, 1986, to 4/12/86, 1986, that (I) (we) last saw the deceased alive on 4/10/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE R. de la Ronda		DEGREE ap		22c. DATE SIGNED 4/12/86															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. de la Ronda		22e. ADDRESS 517 S. Union Ave. Havre de Grace, Md. 21078																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/15/86		23c. NAME OF CEMETERY OR CREMATORY Fawn Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fawn Grove, York Co., PA.													
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA. 17314		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE John Harkins													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-03150

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11647

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GRACE CATHERINE CULLUM			2a. DATE OF DEATH MONTH DAY YEAR 04-06-86			2b. HOUR 12:30a M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 25 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.			
10. CITY OR TOWN OF DEATH Darlington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1502 Deerfield Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Temple			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Lee			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 220-03-6231			17. INFORMANT Alfred E. Cullum			ADDRESS Darlington, MD 1504 Deerfield Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Left Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Reinhardt MD 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Jon Dr Vassar						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/86		23c. NAME OF CEMETERY OR CREMATORY Ascension Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Street Harford MD		
24. FUNERAL DIRECTOR NAME ADDRESS John Harkins 600 Main Street Delta, PA 17313						25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE APR 10 1986 John Harkins-Randall			

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5101-10-0

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2001, 1995, 1992, 1989, 1986, 1983, 1980, 1977, 1974, 1971, 1968, 1965, 1962, 1959, 1956, 1953, 1950, 1947, 1944, 1941, 1938, 1935, 1932, 1929, 1926, 1923, 1920, 1917, 1914, 1911, 1908, 1905, 1902, 1899, 1896, 1893, 1890, 1887, 1884, 1881, 1878, 1875, 1872, 1869, 1866, 1863, 1860, 1857, 1854, 1851, 1848, 1845, 1842, 1839, 1836, 1833, 1830, 1827, 1824, 1821, 1818, 1815, 1812, 1809, 1806, 1803, 1800, 1797, 1794, 1791, 1788, 1785, 1782, 1779, 1776, 1773, 1770, 1767, 1764, 1761, 1758, 1755, 1752, 1749, 1746, 1743, 1740, 1737, 1734, 1731, 1728, 1725, 1722, 1719, 1716, 1713, 1710, 1707, 1704, 1701, 1698, 1695, 1692, 1689, 1686, 1683, 1680, 1677, 1674, 1671, 1668, 1665, 1662, 1659, 1656, 1653, 1650, 1647, 1644, 1641, 1638, 1635, 1632, 1629, 1626, 1623, 1620, 1617, 1614, 1611, 1608, 1605, 1602, 1599, 1596, 1593, 1590, 1587, 1584, 1581, 1578, 1575, 1572, 1569, 1566, 1563, 1560, 1557, 1554, 1551, 1548, 1545, 1542, 1539, 1536, 1533, 1530, 1527, 1524, 1521, 1518, 1515, 1512, 1509, 1506, 1503, 1500, 1497, 1494, 1491, 1488, 1485, 1482, 1479, 1476, 1473, 1470, 1467, 1464, 1461, 1458, 1455, 1452, 1449, 1446, 1443, 1440, 1437, 1434, 1431, 1428, 1425, 1422, 1419, 1416, 1413, 1410, 1407, 1404, 1401, 1398, 1395, 1392, 1389, 1386, 1383, 1380, 1377, 1374, 1371, 1368, 1365, 1362, 1359, 1356, 1353, 1350, 1347, 1344, 1341, 1338, 1335, 1332, 1329, 1326, 1323, 1320, 1317, 1314, 1311, 1308, 1305, 1302, 1299, 1296, 1293, 1290, 1287, 1284, 1281, 1278, 1275, 1272, 1269, 1266, 1263, 1260, 1257, 1254, 1251, 1248, 1245, 1242, 1239, 1236, 1233, 1230, 1227, 1224, 1221, 1218, 1215, 1212, 1209, 1206, 1203, 1200, 1197, 1194, 1191, 1188, 1185, 1182, 1179, 1176, 1173, 1170, 1167, 1164, 1161, 1158, 1155, 1152, 1149, 1146, 1143, 1140, 1137, 1134, 1131, 1128, 1125, 1122, 1119, 1116, 1113, 1110, 1107, 1104, 1101, 1098, 1095, 1092, 1089, 1086, 1083, 1080, 1077, 1074, 1071, 1068, 1065, 1062, 1059, 1056, 1053, 1050, 1047, 1044, 1041, 1038, 1035, 1032, 1029, 1026, 1023, 1020, 1017, 1014, 1011, 1008, 1005, 1002, 999, 996, 993, 990, 987, 984, 981, 978, 975, 972, 969, 966, 963, 960, 957, 954, 951, 948, 945, 942, 939, 936, 933, 930, 927, 924, 921, 918, 915, 912, 909, 906, 903, 900, 897, 894, 891, 888, 885, 882, 879, 876, 873, 870, 867, 864, 861, 858, 855, 852, 849, 846, 843, 840, 837, 834, 831, 828, 825, 822, 819, 816, 813, 810, 807, 804, 801, 798, 795, 792, 789, 786, 783, 780, 777, 774, 771, 768, 765, 762, 759, 756, 753, 750, 747, 744, 741, 738, 735, 732, 729, 726, 723, 720, 717, 714, 711, 708, 705, 702, 699, 696, 693, 690, 687, 684, 681, 678, 675, 672, 669, 666, 663, 660, 657, 654, 651, 648, 645, 642, 639, 636, 633, 630, 627, 624, 621, 618, 615, 612, 609, 606, 603, 600, 597, 594, 591, 588, 585, 582, 579, 576, 573, 570, 567, 564, 561, 558, 555, 552, 549, 546, 543, 540, 537, 534, 531, 528, 525, 522, 519, 516, 513, 510, 507, 504, 501, 498, 495, 492, 489, 486, 483, 480, 477, 474, 471, 468, 465, 462, 459, 456, 453, 450, 447, 444, 441, 438, 435, 432, 429, 426, 423, 420, 417, 414, 411, 408, 405, 402, 399, 396, 393, 390, 387, 384, 381, 378, 375, 372, 369, 366, 363, 360, 357, 354, 351, 348, 345, 342, 339, 336, 333, 330, 327, 324, 321, 318, 315, 312, 309, 306, 303, 300, 297, 294, 291, 288, 285, 282, 279, 276, 273, 270, 267, 264, 261, 258, 255, 252, 249, 246, 243, 240, 237, 234, 231, 228, 225, 222, 219, 216, 213, 210, 207, 204, 201, 198, 195, 192, 189, 186, 183, 180, 177, 174, 171, 168, 165, 162, 159, 156, 153, 150, 147, 144, 141, 138, 135, 132, 129, 126, 123, 120, 117, 114, 111, 108, 105, 102, 99, 96, 93, 90, 87, 84, 81, 78, 75, 72, 69, 66, 63, 60, 57, 54, 51, 48, 45, 42, 39, 36, 33, 30, 27, 24, 21, 18, 15, 12, 9, 6, 3, 0.

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00-04356

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 4 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Alton</i> FIRST MIDDLE LAST <i>F. Daugherty</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>April 19 1986</i>		2b. HOUR <i>4:05</i> AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 18, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 408 ST. JOHN STREET 21078		12b. KIND OF BUSINESS OR INDUSTRY FED GOVT APG	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM S. DAUGHERTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE E. DECKMAN			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217 07 3348	17. INFORMANT ADDRESS MRS. EDNA E. BUCCHI 419 S. WASHINGTON ST. HdG, MD 21078	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCOP</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COOP</i>		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>4-3-86</i> to <i>4-19-86</i> , that (I) (we) last saw the deceased alive on <i>4-19-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
72b. SIGNATURE <i>J. T. Lee</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		72c. DATE SIGNED <i>4/19/86</i>	
72d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. T. Lee</i>		72e. ADDRESS <i>Union Medical Clinic, Havre de Grace</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 22 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY DUBLIN SOUTHERN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE DUBLIN, HARFORD CO., MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 22 1986 Julia Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

SEBIA NOTION NOE

UNION MINTAHD

7/23

0-02860

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 4 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARMON H DUVALL		2a. DATE OF DEATH MONTH DAY YEAR 4 6 86		2b. HOUR 9⁵⁵ PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Howard Co., Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Road Mtn Worker	12b. KIND OF BUSINESS OR INDUSTRY State Highway
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Joppa	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Tom --- Duvall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie --- Tiplov		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-44-8231		17. INFORMANT ADDRESS Joppa, Md. 21085 Mrs. Carrie S. Duvall, 1703 Mountain Road
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Severe Pulmonary Insufficiency, severe (c) Hypertension - probably for cyclic stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a Severe anemia r/t labile leukemic anemia, COPD, ASHD w/ CHF, Cachexia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 86 , to 4/6 , 19 86 , that (I) (we) last saw the deceased alive on 4/6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Manuel M. L...		DEGREE MD		22c. DATE SIGNED 4/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEZATIA, MANUEL		22e. ADDRESS 1131 Bel Air Rd Bel Air, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cemetery, Joppa		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR APR 08 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be signed by a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The first part of the report is a general
 description of the project and its objectives.
 2. The second part is a detailed description of the
 methods used in the study.
 3. The third part is a description of the results
 of the study.

4. The fourth part is a discussion of the
 results and their implications.
 5. The fifth part is a conclusion and
 recommendations for future research.

6. The sixth part is a list of references.
 7. The seventh part is an appendix containing
 additional data and figures.
 8. The eighth part is a list of figures and
 tables.

00-03748

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11650
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph WILLIAM Dye		2a. DATE OF DEATH MONTH DAY YEAR April 15th 1986		2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 8, 1897	
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) PROC. OFFICER		12b. KIND OF BUSINESS OR INDUSTRY FED GOVT (PPVAMC)	
11. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12c. STREET ADDRESS / ZIP CODE 701 SOUTH ADAMS STREET 21078	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH E. DYE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE E. SILLS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. 218 40 7975		17. INFORMANT MRS. AGNES B. DYE		17. ADDRESS SAME AS #13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) pseudobulbar palsy & dysphagia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-11 19 86 , to 4-15 19 86 , that (I) (we) last saw the deceased alive on April 14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bruce T. Yeon M.D.		DEGREE M.D.		22c. DATE SIGNED 4/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 18 APRIL 86		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.		23e. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.		23f. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE <i>Jane Anderson-Henderson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MKS

MILITARY

ACTION 2002

0-04762

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the first examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86 11651				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST OSCAR JOHN GERMAN, JR.				2a. DATE OF DEATH MONTH DAY YEAR 4 21 86		2b. HOUR 8 ³⁰ P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 12 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CO. BD. OF ED.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. CITY OR TOWN BALTO.		13c. INSIDE CITY LIMITS? PERRY HALL YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9728 CROSS RD. 21128			
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR GERMAN SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE ABBIE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1932-1936		17. INFORMANT IRENE GERMAN (WIFE)		ADDRESS SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated Carcinoma of Lung with Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>January 4/21</u> 19 <u>86</u> to <u>April 21</u> 19 <u>86</u> , that (I) (we) lost <u>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>William R. Amoss</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/21/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William R. Amoss</u>		22e. ADDRESS <u>2303 Belair Rd. Fallston Md 21047</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/24/86		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE <u>John E. ...</u>	

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RECEIVED
JAN 27 1971

FOR COLUMBIA

2

00-04457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 11652									
2. DECEASED NAME (TYPE OR PRINT) Robert Johnson Gilley		3. SEX MALE		4. RACE White		5. DATE OF BIRTH Aug. 13, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7a. DATE OF DEATH 4 21 86		7b. HOUR 845A M			
7c. BIRTHPLACE (STATE OR FOREIGN) Penna.		7d. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.									
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery							
13a. STATE Md.		13b. CITY OR TOWN Fallston		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 106 Prospect Mill Rd. 21014									
14. FATHER'S NAME FIRST MIDDLE LAST Walter Frank Gilley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rettie Marintha Blevins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no								16b. SOCIAL SECURITY NO. 171-24-5156		17. INFORMANT ADDRESS Hunter F. Gilley, 108 Prospect Mill Road, Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe electrolyte disturbance with SIADH</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrest at admission 4/9/86</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8:45 AM</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Severe lung disease for 30 yrs or more</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that (1) this hospital attended the deceased from <u>April 11, 1986</u> to <u>April 21, 1986</u> , that (1) (we) last saw the deceased alive on <u>April 20, 1986</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.															
22b. SIGNATURE <u>Albert S. C. Sun</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/21/86</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Albert S. C. Sun, M.D.</u>		22e. ADDRESS <u>1800 Harford Rd. Fallston, MD 21047</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>April 23, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Welcome Home Baptist Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air Harford Md.</u>									
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u>		ADDRESS <u>Baltimore, Md. 21009</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 23 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

1. The first part of the report is a summary of the work done during the year. It is a brief statement of the results of the work, and is intended to give a general idea of the progress made.

2. The second part of the report is a detailed account of the work done during the year. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

3. The third part of the report is a summary of the work done during the year. It is a brief statement of the results of the work, and is intended to give a general idea of the progress made.



00-03329

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 1 6 5 3

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Perry Griffith		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 4 7 86		2b. HOUR 4:12
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> July 27, 1913	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Harpe de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer
13a. STATE Maryland		13b. CITY OR TOWN Frederick		13c. STREET ADDRESS 4909 Ridgecrest Court/ 21701
14. FATHER'S NAME FIRST Howard MIDDLE Griffith LAST Griffith		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Perry LAST Perry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II & Korea 577 07 4996		17. INFORMANT ADDRESS Elizabeth L. Griffith (wife) same as #13a
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) ASCVD - Hypertension Diabete DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion				
ACTUAL SIGNATURE Luis E Renjel		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED 4-7-86
EXAMINER'S NAME (TYPE OR PRINT) LUIS E RENJEL M.D.		ADDRESS 464 QLIHNC ST. 21028		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery
23d. LOCATION CITY OR TOWN Beallsville		COUNTY Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave. Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR APR 11 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

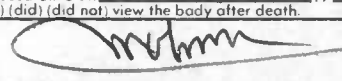
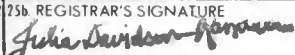
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

00-05317

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 5 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Thomas Gschwind			2a. DATE OF DEATH MONTH DAY YEAR April 29 1986		2b. HOUR 5:45 P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1933		6. AGE (IN YEARS (LAST BIRTHDAY)) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Vernon, N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Churchville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOTE: IN SUCH FACILITY, GIVE STREET ADDRESS) 213 Finney Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Engineer		12b. KIND OF BUSINESS OR INDUSTRY US-govt.	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Gschwind		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Reilly		16. SOCIAL SECURITY NO. 067-26-9285			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Peacetime		16b. SOCIAL SECURITY NO. 1957-59		17. INFORMANT ADDRESS Barbara S. Gschwind, 213 Finney Ave, Churchville, Md. 21028			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma. DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Ca of colon c liver Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.W. Isham		22e. ADDRESS 700 Schuman Cir Hen O'Flaherty Ad Jarr					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 1, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris & Co.		23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.	
24. FUNERAL DIRECTOR NAME Howare K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

151885-00



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 5 5
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VINCENT ROSS GUERCIO			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1986			2b. HOUR 12:30 A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 11, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford County, MD.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 126 Hickory Avenue - Apt. 7				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY TAX	
13a. STATE Maryland			13b. COUNTY Hartford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 126 Hickory Avenue - Apt. 7 21014			14. FATHER'S NAME FIRST MIDDLE LAST Paul — GUERCIO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine — Zito			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES - Army			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT (WIFE) 838-9319 ADDRESS Mrs. Thelma B. Guercio 126 Hickory Avenue - Apt. 7 Bel Air, Maryland 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 1/21/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of the esophagogastric junction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/12/84 , 19 86 , to present , 19 86 , that (I) (we) lost saw the deceased alive on 2/19/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death .									
22b. SIGNATURE M.D., P.A.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 4/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHELE T. CERINO, M.D.			22e. ADDRESS Telephone 1-296-9003 7600 Osler Drive, Towson, Maryland 21024						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Hartford Co., Maryland 21014		
24. FUNERAL DIRECTOR Joseph William Foster Spawville, Md.			50 W. Broadway & Williams St Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611656
REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) ELVA CORRELL HALL			2a. DATE OF DEATH MONTH DAY YEAR 4 3 86		2b. HOUR 6:45 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1 02 01	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY HARFORD	13c. CITY OR TOWN BEL AIR	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD A. CORRELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE BRINEY		13e. STREET ADDRESS / ZIP CODE 26 N. HICKORY AVENUE 21014	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212 12 2528	17. INFORMANT ADDRESS MR. EDWARD N. HALL SAME AS #13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERIO SCLEROSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Sanchez</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WIS F. SANCHEZ		22e. ADDRESS 5 DANHURST CT TOWSON MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY OARLINGTON CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE OARLINGTON, HARFORD CO., MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MO. 21078		25a. DATE REC'D. BY REGISTRAR APR 04 1986	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a day of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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00-03179

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS. PAGES 1, 2, AND 3 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jerry V. Hamm						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 3 1986 2b. HOUR OF ESTIMATED DEATH 19 16 60					
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 17 40		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 3 1986		2d. HOUR OF DEATH 19 16 11		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH Street		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1114 BRIGGSDOWN RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE Md		13b. COUNTY HARFORD		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS at above 21154			
14. FATHER'S NAME FIRST MIDDLE LAST VANCE E. HAMM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BLACKBURN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-38-2222		17. INFORMANT ADDRESS Personal papers					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E. Renjer				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE SIGNED 4-3-86			
EXAMINER'S NAME (TYPE OR PRINT) LUIS E Renjer				ADDRESS 464 Calhoun St Harf							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 7, 1986		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GDNS.				23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS JOHN H. HARKINS, 600 MAIN ST., DELTA, PA.						25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendell			

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0-04733

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas Patrick Hanlon			2a. DATE OF DEATH MONTH DAY YEAR April 20, 1986			2b. HOUR 9:05 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 19, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Baldwin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Park Road 21013	
14. FATHER'S NAME FIRST MIDDLE LAST James Hanlon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dalton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-38-0100		17. INFORMANT ADDRESS W. Harvey Lynch Stewartstown, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Atherosclerosis DUE TO OR AS A CONSEQUENCE OF Bilateral amputation, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hydes, Baltimore, Md.					
22. I certify that (I) (this hospital) attended the deceased from 4/20/86 to 4/20/86 , that (I) (we) last saw the deceased alive on 4/20/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE John D. Van		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/86			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Van		22d. ADDRESS Hydes, Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/1986		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hydes, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.				25a. DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodden			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Section

APR 19, 1955

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00-05020

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 5 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANET L. HARDIMAN			2a. DATE OF DEATH MONTH DAY YEAR 4 23 86			2b. HOUR 11:20 AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 26 48		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 0 0	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
13. CITY OR TOWN OF DEATH Joppa		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 832 Ring Factory Rd.				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		16. KIND OF BUSINESS OR INDUSTRY Homemaking			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Joppa				18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS / ZIP CODE 832 Ring Factory Rd. 21085 Joppa, Md.					
20. FATHER'S NAME FIRST MIDDLE LAST Felix E. Baker				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arlyn M. Leib				22. ADDRESS Joppa, Md.			
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		24. IF YES, GIVE WAR OR DATES		25. SOCIAL SECURITY NO. 215-54-1692		26. INFORMANT Warren Hardiman 832 Ring Factory Rd.					
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer to Brain 6 months DUE TO, OR AS A CONSEQUENCE OF (c) Lung Cancer 1-2 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Strong smoking history											
28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED				30. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE							
38. I certify that (I) (this hospital) attended the deceased from 4/19/86 to 4/23/86, that (I) (we) lost saw the deceased alive on 4/19/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
39. SIGNATURE Dean Miller				40. DEGREE MD				41. DATE SIGNED 4/24/86			
42. PHYSICIAN'S NAME (TYPE OR PRINT) David McClure MD				43. ADDRESS 1131 Belair Rd. Fallston, Md.							
44. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		45. DATE 4-24-86		46. NAME OF CEMETERY OR CREMATORY Westview Mem. Park				47. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
48. FUNERAL DIRECTOR NAME E.F. Lassahn F.H. Kingville, Md. 21087				49. ADDRESS 11750 Belair Rd.		50. DATE REC'D. BY REGISTRAR APR 28 1986		51. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the certificate from the permit. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

BP

NAME: [illegible] ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DATE: [illegible] TIME: [illegible] BY: [illegible]

REASON: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

PRINTED NAME: [illegible]

DATE: [illegible]

TIME: [illegible]

BY: [illegible]

REASON: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

PRINTED NAME: [illegible]

DATE: [illegible]

TIME: [illegible]

BY: [illegible]

REASON: [illegible]

00-03493

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11660
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marion E Harris			2a. DATE OF DEATH MONTH DAY YEAR April 12 1986			2b. HOUR OF 8 AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18. 1936			6. AGE (IN YEARS LAST BIRTHDAY) 49 yrs. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Earl W. LaRue, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Milburn			13e. STREET ADDRESS / ZIP CODE 32 Collins Drive 21903			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-50-4915		17. INFORMANT ADDRESS Clyde J. Harris, Perryville, Md. 21903 32 Collins Drive				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U. S. + Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 2 years.								18b. UNDERLYING CAUSE OF DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Multiple Sclerosis									
19a. DATE OF OPERATION 4-12-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple Sclerosis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> A) WORK B) NOT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-12-86 to 4-12-86 , that (I) (we) last saw the deceased alive on 4-12-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, did not) view the body after death.									
22b. SIGNATURE Edward C. Loo, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D.			22e. ADDRESS Hare de Grace, Md. 21078						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 1986		23c. NAME OF CEMETERY OR CREMATORY Jones Mem. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Md.		
24. FUNERAL DIRECTOR Lee A. Patterson & Son			25a. DATE REC'D. BY REGISTRAR APR 14 1986			25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please send the certificate, page 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-03423



00-04466

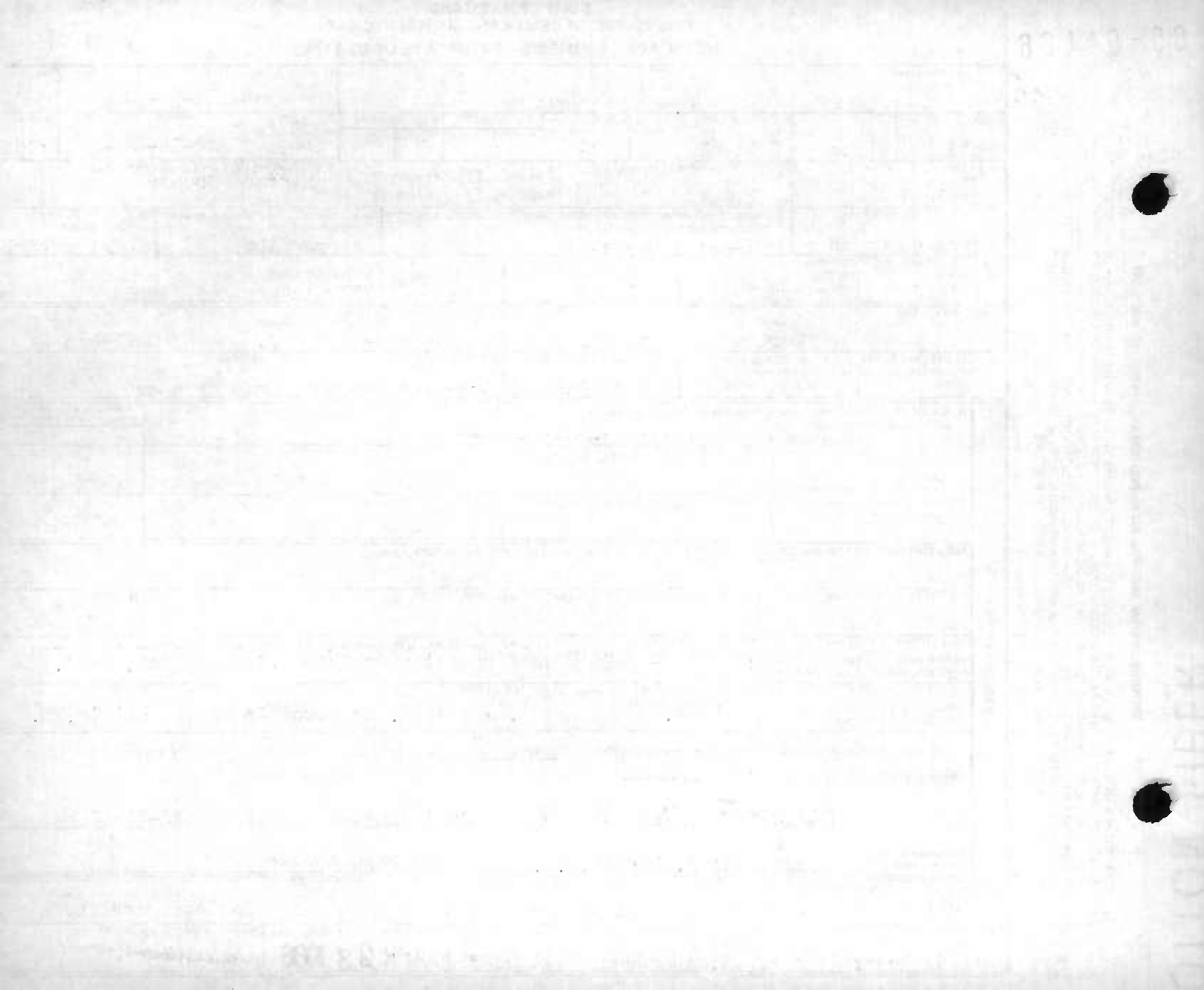
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 1 6 6 1

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				3. DATE OF BIRTH				4. AGE (IN YEARS LAST BIRTHDAY)				5. IF UNDER 1 YR.				6. DATE PRONOUNCED DEAD				7b. HOUR			
BRUCE				4-20-86				3-31-62				24 YRS.								3:45a							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland				U.S.A.								Harford County															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Havre de Grace				Harford Memorial Hospital				Laborer/Etc.				Construction															
13a. STATE				13b. CITY OR TOWN				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS											
Maryland				Harford				Bel Air				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				727 Hickory Ave./21014											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT											
R. Burton Hawkins				Charlotte J. Callahan				NO				213-86-8871				Lynn Ann Hawkins, Same as Above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) Multiple injuries																											
DUE TO, OR AS A CONSEQUENCE OF																											
(b)																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?																			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED																			
				2:40A 4-20-86				Driver of auto crossed over center line, ran off roadside striking fixed object, subj. ejected																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. CITY OR TOWN				COUNTY				STATE											
				Hwy.				Rt. 22 1/10 E. of Fountain Green				Belair, Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:				Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED																			
Margarita A. Korell, M.D.				Assistant				21-86																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
Margarita A. Korell, M.D.				111 Penn Street																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION															
Burial				4-23-86				Bel Air Mem. Gdns.				Bel Air, Harford, Maryland															
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				APR 23 1986				John Davidson																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



0-03751

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11662
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) B. HILL		2a. DATE OF DEATH MONTH DAY YEAR 4 13 86		2b. HOUR 9:28 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Princeton, W.Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Installation-Service Manager		12b. KIND OF BUSINESS OR INDUSTRY Refrigeration A.C. Htg
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Abingdon	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1004 Vernon Court 21009
14. FATHER'S NAME FIRST MIDDLE LAST Lundy Clinton Hill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Margaret Howell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1957-1960 Peacetime		17. INFORMANT ADDRESS 21009 Ann R. Hill, 1004 Vernon Court, Abingdon, Md.	
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Underlying Coronary artery disease</u> (c) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> 19 <u>86</u> to <u>4/13</u> 19 <u>86</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>4/3</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>Barry W. O'Hara</u>		DEGREE M.D. - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry W. O'Hara		22e. ADDRESS 2003 Rock Spring Rd. Forest Hill Md. 21050			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR APR 16 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner has the authority to require an autopsy.

BP

0-03421

UNCLASSIFIED

DATE 11/11/03 BY SP-10



20% CO. 10M LIGER

APR 18 2004

03615

00-03615

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 1 6 6 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA VIRGINIA HOPKINS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 11, 1986		2b. HOUR P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 14, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 REVOLUTION STREET #407		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) PROPERTY OFFICER		12b. KIND OF BUSINESS OR INDUSTRY FED GOVT (APG)
13a. STATE MD			13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 100 REVOLUTION ST. #407 21078		
14. FATHER'S NAME FIRST MIDDLE LAST HARRY G. HOPKINS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORSENA BESTER HINKSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 22 0741		17. INFORMANT ADDRESS HARRY G. HOPKINS 833 PRIESTFORD RD. OARLINGTON, MD. 21034	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>Dante Monakil</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 14 APRIL 86
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL, MD.			22e. ADDRESS 622 SOUTH UNION AVENUE, HAVRE de GRACE, MD. 21078		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 14 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY SPESUTIA CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PERRYMAN, HARFORD CO., MARYLAND	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			25a. DATE RECD. BY REGISTRAR APR 15 1986		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FIBER



1234567890

1234567890

1234567890

0-04355

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8611664

1. DECEASED NAME (TYPE OR PRINT) LUCY CECILE HUFFMAN			2a. DATE OF DEATH MONTH DAY YEAR April 19, 1986		2b. HOUR 5:35 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 13, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Auburn, N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse	12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 1501 Dundee Court 21014		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Donovan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --		16b. SOCIAL SECURITY NO. 088-26-5652	17. INFORMANT ADDRESS Mrs. Nancy Orr, 1501 Dundee Court, Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive A. S. C. V. D.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrence Strokes					24/15
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/19 86 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4119 86 to 4119 86	
22a. I certify that (I) (this hospital) attended the deceased from 4/19 86 to 4/19 86 , that (I) (we) lost saw the deceased alive on 4/19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dudley Phillips				22c. DATE SIGNED 4-19-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips, M.D.				22e. ADDRESS Darlington, Md. 21034	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 23, 1986	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery Fleming		23d. LOCATION CITY OR TOWN COUNTY STATE Cayuga New York
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR APR 22 1986		
			25b. REGISTRAR'S SIGNATURE Judith Davidson-Henderson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

1-81-325

85817 MC 100



Zurück, allmählich

00-03745

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George W Johnson		2a. DATE OF DEATH MONTH DAY YEAR April 11 1986		2b. HOUR 11:45 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 16 1911	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. DATE OF BIRTH MONTH DAY YEAR 2 16 1911	
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. DATE OF BIRTH MONTH DAY YEAR 2 16 1911	
15. CITY OR TOWN OF DEATH Harre DeGrace		16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		17. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		19. STATE MD		20. COUNTY Cecil	
21. CITY OR TOWN Rising Sun		22. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23. STREET ADDRESS / ZIP CODE 8 ANGLIA LN 21911	
24. FATHER'S NAME FIRST MIDDLE LAST EMMITT JOHNSON		25. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOLA JOHNSON		26. ADDRESS JOHNSON	
27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		28. SOCIAL SECURITY NO. WWII 218-054684		29. INFORMANT EVA F. JOHNSON (SAME AS 13)	
30. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) COPD & asthmatic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) COP pulmonary		31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
32. DATE OF OPERATION		33. CONDITION FOR WHICH OPERATION WAS PERFORMED		34. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
35. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		36. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
38. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		39. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		40. LOCATION CITY OR TOWN COUNTY STATE Columbia Cecil MD.	
41. I certify that (I) (this hospital) attended the deceased from April 8 1986 to April 11 1986, that (I) (we) last saw the deceased alive on 4/11 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
42. SIGNATURE Brian T. Jones MD		43. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		44. DATE SIGNED 4/11/86	
45. PHYSICIAN'S NAME (TYPE OR PRINT)		46. ADDRESS			
47. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		48. DATE 4/14/86		49. NAME OF CEMETERY OR CREMATORY West Nottingham	
50. FUNERAL DIRECTOR NAME RT FOARD Funeral Home		51. ADDRESS Rising Sun MD		52. DATE REC'D. BY REGISTRAR APR 16 1986	
53. REGISTRAR'S SIGNATURE		54. REGISTRAR'S SIGNATURE			

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00-06132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR Unknown #86-17 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 6 6 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
David						Jones		ESTIMATED		2/10/		19		86		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	9 6 49		36 YRS.						2/13/		19		86		2:55 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.		WIDOWED		DIVORCED		Harford County,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Aberdeen		Off Ramp Northbound I-95		Trashman		Sanitation											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
New York		COUNTY		E.ELmhurst		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		23-30 100th Street								11369	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
						Ruby				Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		N/A		Denise R. Jones		194-29 114th Road											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Gunshot Wound to Head & Neck</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost.																	
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>																	
(c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
<input checked="" type="checkbox"/>		HOUR A.M. MONTH DAY YEAR		subject shot													
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		wooded area		Northbound Ramp I-95, Aberdeen, Harford, Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		M.D. Assistant		2/14/86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		5/9/86		Silver Mount Cemetery		S.Island,						N.Y.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
March Funeral Homes		1101 East North Avenue		MAY 9 1986		[Signature]											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
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00-05007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611667
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MARIAN		MIDDLE E.		LAST JONES		2a. DATE OF DEATH MONTH DAY YEAR 4 / 22 / 1986		2b. HOUR 6 ¹⁵ P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN DARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 161 DARLINGTON Rd. 21034					
14. FATHER'S NAME FIRST MIDDLE LAST Ocellous Berry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Jones											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-76-4913		17. INFORMANT Henry H. Jackson		ADDRESS P.O. Box 232 Darlington, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL DEATH DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension and DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from March 3, 1986, to April 22, 1986, that (I) (we) last saw the deceased alive on April 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dante Monarick		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONARICK		22e. ADDRESS Havre de Grace, Md 21078											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/1986		23c. NAME OF CEMETERY OR CREMATORY Hosana Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Darlington, Harford, Md.							
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR APR 29 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send 2 copies of this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

OFFICE OF THE ATTORNEY GENERAL

• A • E • U

APR 29 1966

00-04354

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 6 8
REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE) WILLIAM YAGER KEANE, SR.			2a. DATE OF DEATH MONTH DAY YEAR April 19, 1986		2b. HOUR 11 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1924		
6. AGE (IN YEARS LAST BIRTHDAY) 61		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1406 Brierwood Court		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engr.		12b. KIND OF BUSINESS OR INDUSTRY US-Govt.		13. STREET ADDRESS / ZIP CODE 1406 Brierwood Court 21085		
14. FATHER'S NAME FIRST MIDDLE LAST Russell William Keane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Powell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		
17. INFORMANT ADDRESS Joppa, Md. 21085		18. SOCIAL SECURITY NO. 215-16-2932		19. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) General Debilitation DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/85		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.		
22a. I certify that (I) (this hospital) attended the deceased from 4/1/86 to 4/20/86 that (I) (we) last saw the deceased alive on 4/20/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not autopsied the body after death.						
22b. SIGNATURE Robert L. Smith, M.D.		22c. ADDRESS Fallston		22d. DATE SIGNED 4-20-86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Union Chapel Methodist		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE J. Davidson		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

20% COTTON 50% 2

WILKINSON



00-052344

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611669
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Brooke C. Keller</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>April 28 1986</i>		2b. HOUR P <i>9:10</i>						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 14, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE		
13a. STATE MD		13b. COUNTY DECEL		13c. CITY OR TOWN PERRYVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 204 CONCORD APTS. 21903			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ADAM KELLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLIE BECKER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 166 18 9472		17. INFORMANT MRS. ESTHER K. KELLER				ADDRESS SAME AS #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John D. Yun</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/29/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Yun</i>						22e. ADDRESS <i>Havre de Grace, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3MAY86		23c. NAME OF CEMETERY OR CREMATORY LAUREL DALE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE READING, BERKS COUNTY, PA.				
24. FUNERAL DIRECTOR NAME LAMN & WITMAN WERNERSVILLE, PA 19565 ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR <i>APR 30 1986</i>			25b. REGISTRAR'S SIGNATURE		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1055-00

00-02783

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST D. KENDRICK			2a. DATE OF DEATH MONTH DAY YEAR APRIL 4, 1986		2b. HOUR 7:00P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 17, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2100 CHAPEL ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) DRIVER		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2100 CHAPEL ROAD 21078	
14. FATHER'S NAME FIRST MIDDLE LAST CLEVE KENDRICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLA FOWLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 431 16 4380		17. INFORMANT ADDRESS MRS. HAZEL M. KENDRICK SAME AS #13e	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Luis E. Renjel</u>		DEGREE MD		22c. DATE SIGNED 5 APRIL 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS E. RENJEL, M.D.		22e. ADDRESS 464 ALLIANCE STREET HAVRE de GRACE, MD. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8 APRIL 86	23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE DE GRACE, HARFORD CO, MD.	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR APR 01 1986		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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General Purpose
Carriage
Carriage

Jan 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CORNELIA						KIRK		4 16 86		1125PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		7 10 03				82 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.						HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
FALLSTON		FALLSTON GENERAL HOSP.									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Teacher											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Harford		Bel Air				308 Linwood Ave. 21014			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edward C. Wilson				Virginia Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		212-38-2515		10617		Johns Hopkins Rd.		Ms. Rosalee Kirk Laurel, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE MYOCARDIAL INFARCTION</u>										HOW	
(c) <u>ATHEROSCLEROSIS</u>										YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Subcutaneous Emphysema ? ESOPHAGEAL RUPTURE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
20d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		20f. LOCATION STREET CITY OR TOWN COUNTY STATE							
21. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>86</u> , to <u>4/16</u> 19 <u>86</u> , that (I) (we) lost the deceased alive on <u>4/16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <u>Barry A. Work M.D.</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. ADDRESS							
BARRY A. WORK M.D.				2003 ROCKSPRING RD. FARM HILL, MD 21050							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Removal		4-16-86									
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Anatomy Board						APR 22 1986		<u>John Davidson Hendrick</u>			
ADDRESS						Balto., Md.					

BP

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]



Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

00-05063

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8611672

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Velma</u> MIDDLE: <u>Palmer</u> LAST: <u>Krauss</u>			2a. DATE OF DEATH MONTH: <u>April</u> DAY: <u>23</u> YEAR: <u>1986</u>			2b. HOUR <u>11:07</u> ^P					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH: <u>June</u> DAY: <u>23</u> YEAR: <u>1905</u>		6. AGE IN YEARS LAST BIRTHDAY: <u>81</u>		IF UNDER 1 YEAR MONTHS: _____ DAYS: _____		IF UNDER 24 HRS HOURS: _____ MIN: _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Hartford</u> MD.					
10. CITY OR TOWN OF DEATH <u>Harrode Grace</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Hartford Memorial Hosp.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>MD</u>						13b. COUNTY <u>Hartford</u>		13c. CITY OR TOWN <u>Aberdeen</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: <u>Newton</u> MIDDLE: <u>E.</u> LAST: <u>Palmer</u>						15. MOTHER'S MAIDEN NAME FIRST: <u>Esther</u> MIDDLE: _____ LAST: <u>Hall</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>214-16-9442D</u>		17. INFORMANT ADDRESS: <u>Aberdeen, MD 21001</u> <u>Richard P. Krauss, 310 W. Bel Air Ave.,</u>					
18. CAUSE OF DEATH (Enter only one cause per line for each part) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 <u>86</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK _____ AT WORK _____				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> 19 <u>86</u> to <u>4-23</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dante Monakil</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				7b. DATE SIGNED <u>4/24/86</u>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANTE MONAKIL</u>				22d. ADDRESS <u>Harrode Grace Rd 21078</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>4/27/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baker Cemetery</u>		23d. LOCATION CITY OR TOWN: <u>Aberdeen</u> COUNTY: <u>Hartford</u> STATE: <u>Maryland</u>			
24. FUNERAL DIRECTOR NAME: <u>Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399</u>				25a. DATE OF DEATH BY DECEASED <u>APR 29 1986</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WINTERHILL

100% COTTON LINES

[Faint, mostly illegible handwritten text, possibly a letter or document.]

APR 25 1964

00-04745

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MON. DAY YEAR		2b. HOUR HRS. MIN.	
Noraetta		Fowler		Kurtz				4/19/86		11:45 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Sept. 24, 1911		74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Kentucky		U.S.A.				Harford MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hospital						Teacher		School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
Maryland				Harford		Darlington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1839 Castleton Rd. 21034	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Hamer Forman Fowler				Anna Elizabeth Dillon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				403-42-8096		Judith Juergensen same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>General Debilitation</i>											
(c) <i>Widely disseminated adenocarcinoma of breast</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.											
22b. SIGNATURE <i>R. L. Smith</i>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Robert L. Smith											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/21/1986		Oak Grove Cem.		Churchville, Harford, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M. Gladden Kurtz Jarrettsville, Md.						APR 24 1986		<i>Julia Davidson-Randall</i>			

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00-049091

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11674
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen N. Labby			2a. DATE OF DEATH MONTH DAY YEAR April 22 1986			2b. HOUR 11:36 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 29 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Havee de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7400 Gunpowder Road 21220		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Weitzel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Cook						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-09-3130		17. INFORMANT ADDRESS Lewis B. Labby, Jr. Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CHF (c) CHF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 85 to Apr. 22 86 , that (I) (we) lost Apr. 22 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If signed and did not see the body after death.)									
22b. SIGNATURE Linda Freilich			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA FREILICH			22e. ADDRESS 1604 Churchville Road						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/25/1986		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222					25a. DATE REC'D. BY REGISTRAR APR 28 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be the duty of the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

BP

00-024481

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11675

1. DECEASED NAME (TYPE OR PRINT) FORDMAN D LARISON			2a. DATE OF DEATH MONTH DAY YEAR 4-1-86			2b. HOUR 11:20 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH HAYRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) MUSICIAN		12b. KIND OF BUSINESS OR INDUSTRY ENTERTAINMENT		
13a. STATE MD			13b. COUNTY HARFORD		13c. CITY OR TOWN HAYRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 505 CONGRESS AVENUE #507 21078	
14. FATHER'S NAME FIRST MIDDLE LAST FRED LARISON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LETTIE ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 218 18 0206A		17. INFORMANT ADDRESS MRS. GLADYS R. LARISON SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis (b) Cerebrovascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic obstructive lung disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION 3/25/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (i) (this hospital) attended the deceased from 3-3-86 to 4-1-86 that (i) (we) last saw the deceased alive on 3-3-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (and) not view the body after death.										
23a. SIGNATURE [Signature]			DEGREE			23b. DATE SIGNED 4/1/86				
23c. PHYSICIAN'S NAME (TYPE OR PRINT) H. ANAKAWA M.D.			23d. ADDRESS 319 N. Union Ave HAYRE DE GRACE MD.							
23e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2 APRIL 86		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAYRE DE GRACE, HARFORD CO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAYRE DE GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR APR 03 1986		25b. REGISTRAR'S SIGNATURE Gloria Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-02440

RECEIVED

RECEIVED

RECEIVED



0-06240

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 7 6
REG. NO.

1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) LILLIE LEE			2a. DATE OF DEATH MONTH 4 DAY 30 YEAR 86			2b. HOUR 10:15 AM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Oct 16, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS			7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.						
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY) CITIZENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Self Emp			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Harford 13c. CITY OR TOWN Darlington				13d. INSIDE CITY (LIMITS)? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Cedar Church Rd. 21034						
14. FATHER'S NAME ?				15. MOTHER'S MAIDEN NAME Onzue Mary				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATE) -				
16b. SOCIAL SECURITY NO. 263-36 3280				17. INFORMANT ADDRESS Mayorie Minus - Washington, D.C.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old left hip fracture DUE TO, OR AS A CONSEQUENCE OF, CS Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) ASGAP DUE TO, OR AS A CONSEQUENCE OF, ASGAP (c) ASGAP												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
23a. SIGNATURE J. T. Lee				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED 5/3/86		
23c. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. Lee				23d. ADDRESS Union Med. Clinic, Md.								
24a. BURIAL, CREMATION, REMOVAL (CHECK) Burial				24b. DATE May 3, 1986		24c. NAME OF CEMETERY OR CREMATORY St. James UAME Cem.		24d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.				
25. FUNERAL DIRECTOR Clelia J. Bullard				ADDRESS Harve de Grace, Md.				25a. DATE RECD. BY REGISTRAR MAY 13 1986				
25b. REGISTRAR'S SIGNATURE John H. H. H.												

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Manhattan Library
Cotton Club Bldg
New York - Washington
D.C.

Manhattan Library
Cotton Club Bldg
New York - Washington
D.C.

00-05371

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8-6 REG. NO. 11677			
1. DECEASED NAME (TYPE OR PRINT) LINDA M. LEE				2a. DATE OF DEATH MONTH DAY YEAR 4 30 86				2b. HOUR 1532			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Belair		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 401 Old Joppa Rd., 21014			
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Mollineux				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 20 8444		17. INFORMANT ADDRESS Patricia J. Stang, Balto., MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>laryngeal edema</u> (c) <u>intubation secondary to subdural hematoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Constrictive heart failure, Pleural effusion, pneumonia</u>											
19a. DATE OF OPERATION <u>3/29/86 4/1/86</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Subdural Hematoma</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS INVOLVING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NAME OF PLACE IN ITEM 13b PART 1 OR PART 2) <u>Patient fell at Harbor Mall.</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Harbor Mall</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>1216 Harford Road Fallston Md</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>86</u> , to <u>4/30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not see the body after death)											
22b. SIGNATURE <u>Dr. Douglas Abbott</u>				22c. DEGREE <u>MD</u>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>4/30/86</u>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Douglas Abbott</u>				22g. ADDRESS <u>1216 Harford Road Fallston Md</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/2/86		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Hardison</u>					

17870-0

17870-0

MD	Unknown	MD	Unknown
Fallston	Fallston General Hospital	Fallston	Fallston General Hospital
USA	USA	USA	USA
Harford County	Harford County	Harford County	Harford County
MD	MD	MD	MD
Unknown	Unknown	Unknown	Unknown
MD	MD	MD	MD

Green Mount
Henry W. Johnson & Son, Co.
Baltimore, MD
21012

0-03494

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11678	
1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cary N Leonard Sr.												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4-7-1986	
3 SEX M	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 2 19 19	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 67	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEATH MONTH DAY YEAR 4-7 1986	2d. HOUR 1:30 PM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.				
10. CITY OR TOWN OF DEATH Havre De Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Owner		12b. KIND OF BUSINESS OR INDUSTRY self Emp.					
13a. STATE MD		13b. CITY OR TOWN Cecil		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 32 Cedar Dr.		P.O. Box 14					
14. FATHER'S NAME FIRST MIDDLE LAST John Leonard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Hudson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 420 14 5591		17. INFORMANT ADDRESS Helen M. Leonard, Port Deposit, Maryland.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Heart Disease DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Luis E. Renjel		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER				DATE SIGNED 4-7-86					
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance St. HavreDeGrace, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 10, 1986		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit, Cecil, Maryland.					
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.				25a. DATE REC'D. BY REGISTRAR APR 14 1986				25b. REGISTRAR'S SIGNATURE					

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1. *Chlorophyll* 2. *Carotenoids* 3. *Xanthophylls*

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Index

See (1) *University of London* . 2000 .

00-03455

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11679
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NELLIE R. LOWE			2a. DATE OF DEATH MONTH DAY YEAR 4 9 1986		2b. HOUR P 6:50 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 5, 1905		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LA.		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) PRACTICAL NURSE		
12b. KIND OF BUSINESS OR INDUSTRY FED GOVT APG		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD				
13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 505 CONGRESS AVE 21078		14. FATHER'S NAME FIRST MIDDLE LAST DAVID MARTIN WELCH				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEATHA JANE OWENS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 219 16 6072		17. INFORMANT ADDRESS MRS. JEAN E. ANGELUCCI 605 LEGION OR. HdG, MD 21078				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL DEATH DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/1/81 to 4/9/86 , that (I) (we) last saw the deceased alive on 4/9/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dante Monakul		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/10/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKUL		22e. ADDRESS Havre de Grace Md 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12 APRIL 86		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GAROENS		
23d. LOCATION CITY OR TOWN COUNTY STATE ALDINO, HARFORD CO., MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				
25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

02:5 3881 9 4

LOVE

HEALTH

HAROLD COUNTY

CLINTON HOSPITAL

HAVE INSURANCE



WATFORD
COLLINS

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "John D. Smith".

-05395

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified immediately.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611680
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT BARGER MAGNESS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 30, 1986			2b. HOUR 6 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT. 21, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Abingdon, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			
10. CITY OR TOWN OF DEATH Abingdon		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 312 Amy Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tax Assessor		12b. KIND OF BUSINESS OR INDUSTRY State Government	
13a. STATE Maryland			13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 700 Heritage Lane 21014		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Magness				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Treadwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Bel Air, Md. 21014 Virginia C. Magness, 700 Heritage Lane					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung and DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a) Severe Dementia (Alzheimer's)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/1/86 19 86 , to 4/30 19 86 , that (I) (we) last saw the deceased alive on 4/24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dudley Phillips				DEGREE M.D.				22c. DATE SIGNED 4-30-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips, M.D.				22e. ADDRESS Masonic Bldg., Darlington, Md. 21034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 3, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Francis de Sales Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

BP



00-03122

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 NO. 11081

1. DECEASED NAME (TYPE OR PRINT) LOUISE MARIE LOUISE MATASSA		2a. DATE OF DEATH (April 4, 1986)		2b. HOUR 8:28 P.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 24, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FANSTON Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditing OFFICE	12b. KIND OF BUSINESS OR INDUSTRY Department Store
13a. STATE Maryland	13b. COUNTY Harford Co.	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1819 Ridgescroft Drive 21050
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Jerardi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 219-20-5477	17. INFORMANT (Son) 879-17821 ADDRESS 1819 Ridgescroft Drive MR. VINCENT L. MATASSA Forest Hill, Maryland 21050		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Disease (b) Arteriosclerotic Cardiovascular Disease (c) Arteriosclerotic Cardiovascular Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebrovascular Hemorrhage, Rt Temporal, Occipital				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 3-21- 19 86 , to 4-4- 19 86 , that (I) (we) last saw the deceased alive on 4-4- 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Hermit P. Bonovich		DEGREE M.D.		22c. DATE SIGNED 4-4-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 7, 1986	23c. NAME OF CEMETERY OR CREMATORY NEW Cathedral Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St. Baltimore, Maryland 21014		25a. DATE REC'D. BY REGISTRAR APR 8 1986		
25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers, page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. NAME WILLIAM J. HARRIS
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge

2. NAME WILLIAM J. HARRIS
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge



3. NAME WILLIAM J. HARRIS
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge
DATE 10/15/54
PLACE Fort Monmouth, N.J.
REASON Discharge
REMARKS Discharge

0-05030

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 8 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha E. R. McBride			2a. DATE OF DEATH MONTH DAY YEAR 4-18-86			2b. HOUR 1057 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 08-20-02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Street, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hawford MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Seamanstress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Hawford		13c. CITY OR TOWN Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Main Street 21024	
14. FATHER'S NAME FIRST MIDDLE LAST SILAS L. ROSS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA WONDERS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-1897		17. INFORMANT ADDRESS WHITEFORD, MD ELAINE THOMPSON 1730 RIDGE RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 18, 1986, to April 18, 1986, that (I) (we) last saw the deceased alive on N/A 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.									
22b. SIGNATURE Michael Hamilton MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J MICHAEL HAMILTON MD				22e. ADDRESS FALLSTON GRN HOSP, FALLSTON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-22-86		23c. NAME OF CEMETERY OR CREMATORY CENTRE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE NEW PARK YORK PA			
24. FUNERAL DIRECTOR NAME JOHN HARRIS				ADDRESS 600 MAIN ST. DELTA PA		25a. DATE REC'D. BY REGISTRAR APR 28 1986			
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

COPIES OF THE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rebecca A McMillan				2a. DATE OF DEATH MONTH DAY YEAR April 12, 1986		2b. HOUR 11:30 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sparta, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dishwasher		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David Martin Moxley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Halsey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-32-8489	
17. INFORMANT ADDRESS Bel Air, Md. 21014		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO, OR AS A CONSEQUENCE OF (b) A.S. C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Serulitis SPECIFY INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Obstructive jaundice poss. due to Ca. of the bile duct		20. DATE OF OPERATION 4-1-86	
21a. DATE OF OPERATION 4-1-86		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED 4-1-86		22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER SATISFY MEDICAL EXAMINERS) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 4-1-86		23d. LOCATION CITY OR TOWN COUNTY STATE Harford	
24a. INJURY OCCURRED 4-1-86		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, Etc.) 4-1-86		24c. LOCATION CITY OR TOWN COUNTY STATE Harford		24d. LOCATION CITY OR TOWN COUNTY STATE Harford	
25a. I certify that (I) (this hospital) attended the deceased from 4-1-86 to 4-12-86 , that (I) (we) lost saw the deceased alive on 4/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		25b. SIGNATURE Edward C. Loo, MD		25c. DEGREE MD		25d. DATE SIGNED 4/12/86	
26a. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, MD		26b. ADDRESS Harford		26c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		26d. DATE SIGNED 4/12/86	
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		27b. DATE April 16, 1986		27c. NAME OF CEMETERY OR CREMATORY Piney Creek Methodist Cemetery		27d. LOCATION CITY OR TOWN COUNTY STATE Piney Creek Alleghany N.C.	
28. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		29. DATE REC'D. BY REGISTRAR APR 14 1986		30. REGISTRAR'S SIGNATURE Juanita Anderson-Randall		31. REGISTRAR'S SIGNATURE Juanita Anderson-Randall	

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0-02862

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11684
REG. NO.

1- FOR
STATE
REGISTRAR

2a. DECEASED NAME (TYPE OR PRINT) Lillian Marie Myers		2b. DATE OF DEATH MONTH DAY YEAR 4 3 86		2c. HOUR 10 10 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 5 1902	
6. AGE (IN YEARS LAST BIRTHDAY) 83		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. DATE OF BIRTH MONTH DAY YEAR Aug. 5 1902	
12. CITY OR TOWN OF DEATH Harford		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
15. STATE Md.		16. CITY OR TOWN Perryville		17. STREET ADDRESS / ZIP CODE Broad St. 21903	
18. FATHER'S NAME FIRST MIDDLE LAST Charles E. Norman		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertina Gallaway		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
21. SOCIAL SECURITY NO. 215-34-5273		22. INFORMANT NAME ADDRESS Thomas W. Myers P.O. Box 57		23. CITY OR TOWN Perryville, Md.	

24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Angioma, Pulmonary effusion DUE TO, OR AS A CONSEQUENCE OF (c) Acute cardiac failure, myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVING CAUSE OF DEATH Carcinoma Breast, Metastatic Breast Cancer	
25a. DATE OF OPERATION	25b. CONDITION FOR WHICH OPERATION WAS PERFORMED
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
27a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
28a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
29a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 86 , to 4/4 , 19 86 , that (I) (we) last saw the deceased alive on 4/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
29b. SIGNATURE Dr. H. Walcott	29c. DATE SIGNED 4/4/86
29d. PHYSICIAN'S NAME (TYPE OR PRINT)	29e. ADDRESS

30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	30b. DATE 4-7-86	30c. NAME OF CEMETERY OR CREMATORY Charlestown Cem.	30d. LOCATION CITY OR TOWN COUNTY STATE Charlestown Cecil Md.
31. FUNERAL DIRECTOR NAME ADDRESS Robert G. H. North East, Md.		32a. DATE REC'D. BY REGISTRAR APR 08 1986	32b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

W. H. H. H.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical and nursing staff are notified by number of beds.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 1 6 8 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DAVID NIXON					2a. DATE OF DEATH MONTH DAY YEAR 4 1 86			2b. HOUR 3:50p M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 12 98			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 3:50p M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Mitchell Lane 21001		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-10-9394			17. INFORMANT ADDRESS Grafton Scenion 1517 Mitchell Lane					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic congestive heart failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) 1. Chronic obstructive pulmonary disease 2. Chronic renal										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from September 19 83 to April 19 86 , that (I) (we) last saw the deceased alive on March 26 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Sanct W. Kim						DEGREE		22c. DATE SIGNED April 2, 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANCT W. KIM						22e. ADDRESS 308 S. Union Ave. Havre de Grace Md. 21088					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 4-4-86		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Arnold Beard 353 Fountain St. Havre de Grace Md.						25a. DATE REC'D. BY REGISTRAR APR 9 1986		25b. REGISTRAR'S SIGNATURE J. A. Davidson-Randall			

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00-05180

FOR
STATE
REGISTRAR

Larry Vincent Nowakowski

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11686
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LARRY V NOWAKOWSKI			2a. DATE OF DEATH MONTH DAY YEAR 4-26-86			2b. HOUR M AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 03 49		6. AGE (IN YEARS LAST BIRTHDAY) YRS 37		7. IF UNDER 1 YEAR MONTHS DAYS 00 00		
8. BIRTHPLACE (STATE OR FOREIGN) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
12. CITY OR TOWN OF DEATH FALLSTON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plaster		15. KIND OF BUSINESS OR INDUSTRY Construction		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN EDGEWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1934 ELOISE LANE 21040		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Nowakowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Zemanski				2222 Monacoey Rd Balto Md 21221		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-52-4645		17. INFORMANT ADDRESS Margaret Nowakowski, Mother		2222 Monacoey Rd Balto Md 21221				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF CRF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 86 to April 26 1986 that (I) (we) lost saw the deceased alive on April 26 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.										
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 4/26/86	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA FREICHT			22d. ADDRESS 1604 Churchville Rd							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery			23d. LOCATION BALTIMORE CO., MD. STATE		
24. FUNERAL DIRECTOR Bruzdinski Funeral Home			1407 Old Eastern Ave			25a. DATE REC'D. BY REGISTRAR APR 30 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-05519

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11687
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN EDWARD OHLER			2a. DATE OF DEATH MONTH 4 DAY 05 YEAR 86		2b. HOUR 11 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Dec. DAY 15 YEAR 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY Black & Dkr.
13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Francis MIDDLE Ohler LAST Ohler			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Shannahan LAST Shannahan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-10-9628		17. INFORMANT ADDRESS 2305 Harford Rd. Mrs. Grace V. Ohler, Fallston, Md. 21047	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) I.A.D. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-25 , 19 86 , to 4-25 , 19 86 , that (I) (we) lost saw the deceased alive on 4-25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Joseph Reinhardt for Dr. Vassar		DEGREE Dr. Vassar		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Reinhardt		22e. ADDRESS Fallston General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-28-1986	23c. NAME OF CEMETERY OR CREMATORY St. John R. C. Ch. Cem.	23d. LOCATION CITY OR TOWN Long Green COUNTY Baltimore STATE Md.
24. FUNERAL DIRECTOR NAME E. F. Lassahn ADDRESS 11750 Belair Rd. Kingsville, Md. 21087		25a. DATE REC'D BY REGISTRAR MAY 02 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all portions of this certificate, page 1 and 2, and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, and medical examiner must be notified or called.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon of parts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11688
REC. NO.

1. DECEASED NAME (TYPE OR PRINT) George Allen Owens			2a. DATE OF DEATH MONTH DAY YEAR 4-27-86			2b. HOUR 6:00 P.M.			
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09-18-09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN HARFORD		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 100 ST MARY'S RD 21132			
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Owens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 220-09-8940		17. INFORMANT ADDRESS Louise Fletcher Pylesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse Interstitial Fibrosis Lung. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis - severe Hypoxaemia (c) H/O Asbestos Exposure, Heavy Smoking. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 4 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/24 1986 to 4/27 1986 that (I) (we) last saw the deceased alive on 4/27 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. PAREKH MD.				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1908 Harford Rd, Fallston MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/30/1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.			
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 01 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson			

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00-04658

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of this permit. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition of the body.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86 NO. 11689		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Lawson Wright Parks, Jr.				4 16 86		8 ⁰⁰ P.		M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
M		Cauc		Sept. 22, 1902		83 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Holland: Isl. Md.		U.S.A.				Harford Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		2019 Laurel Brook Rd.		Elec. Exec.		Western Electric			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2019 Laurel Brook Rd. 21047	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Hance		Pearl		no		215-10-4192		Mrs. Edna Parks, Fallston, Md. 21047	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
Severe Peripheral Vascular Disease, malnutrition, Dehydration									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHEEL <input type="checkbox"/> NOT WHEEL <input type="checkbox"/> AT WHEEL <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY STATE	
				4/15 19 86		4/16 19 86			
22a. I certify that (I, (this hospital) attended the deceased from saw the deceased alive on above (I, (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Willard P. Amos				4/16/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Willard P. Amos		2303 Be air Rd, Fallston, Md 21047							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial		4-19-1986		Baltimore Cemetery		Baltimore		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME		Kingsville, Md. 21087		22 1986					
Lassahn Funeral Home									

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43812 NOTICE NOV

ENCLOSURE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED



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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86		11690		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Harold Clarence Parsons			2a. DATE OF DEATH MONTH DAY YEAR April 22 1986			2b. HOUR 10 4 p.m.			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY US Gov. t.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 58 Duck St. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Parsons			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Marylyn Parsons, Sames as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopneumonic Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 1 hour</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>0</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 86</u> to <u>April 22 19 86</u> , that (I) (we) lost saw the deceased alive on <u>April 22 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mannul M. J.</u>				DEGREE MD		22c. DATE SIGNED 4/23/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAZARD, Mannul</u>				22e. ADDRESS <u>PO Box 519, Aberdeen, MD 21001</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson</u>			

GENERAL MOTORS CORP.

WALTER



0-02858

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11691

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (Type or Print) Claude A. Perry			2a. DATE OF DEATH MONTH DAY YEAR April 3 1986		2b. HOUR 8:35 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 13 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harrode Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. STATE MD				13b. COUNTY CECIL		13c. CITY OR TOWN Rising Sun	
14. FATHER'S NAME FIRST MIDDLE LAST M. J. PERRY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-24-1743		17. INFORMANT ADDRESS KATE G. PERRY (SAME AS 13 ABOVE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF: (c) bronchospneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① Diabetes mellitus ② Pneumothorax							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-2-5 19 86 to 4-3 19 86 , that (I) (we) lost saw the deceased alive on 4-3 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE SANG Sang W. Kim, M.D.				DEGREE M.D.		22c. DATE SIGNED April 3, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM				22e. ADDRESS 308 S. Union Ave. Harrode Grace, MD 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-6-86		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cmtg		23d. LOCATION CITY OR TOWN COUNTY STATE Corona Cecil MD	
24. FUNERAL DIRECTOR NAME ADDRESS Richard L. Goodie Rising Sun Md				25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE John E. ...	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/funeral permit. Then please remove counterparts. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



100%

Handwritten notes and markings, including a large '1' and various scribbles.

Faint, mostly illegible handwritten text and markings covering the majority of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 9 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) REGINA ELIZABETH PERRY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 3, 1986			2b. HOUR 9:30 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Joppa, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2611 Willoughby Beach Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Mobile/Park	
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John --- Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie --- Willick			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no ---			
16b. SOCIAL SECURITY NO. 216-56-6505			17. INFORMANT ADDRESS Edgewood, Md. 21040 Carl S. Perry, Jr., 2611 Willoughby Beach Rd						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 7, 1977 to April 3, 1986 , that (I) (we) last saw the deceased alive on Feb 6 Mar 14, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE [Signature]		22c. DATE SIGNED 4-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR SOMERVILLE		22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Harford, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009				25a. DATE OF REGISTRATION APR 10 1986			

18780-



0-03272

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611693
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL C. PETZ			2a. DATE OF DEATH MONTH DAY YEAR 4 4 86			2b. HOUR 251 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 2 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH BEL AIR MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY 13c. CITY OR TOWN Md. Baltimore Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 406 Register Ave. 21212			
14. FATHER'S NAME FIRST MIDDLE LAST CHRISTIAN F. LINDAVER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE BALD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215078495		17. INFORMANT ADDRESS 1403 Purdue Ct. H. Albert Petz, Jr. Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ARTERIOSCLEROSIS 4 YRS DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION 10 YRS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a HYPERTENSION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/22 19 85 , to 4/14 19 86 , that (I) (we) last saw the deceased alive on 4/4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE Robert J. Rosensteel MD						DEGREE MD		22c. DATE SIGNED 4/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. ROSENSTEEL MD						22e. ADDRESS 3602 CLARET DR. FALLSTON MD 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked "yes," item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

received on 10/10/1964
from the
State of
California
via the
U.S. Postal Service
on 10/10/1964



Enclosed for the
State of California
is a check for the
amount of \$100.00
payable to the
order of the
State of California
for the purpose of
the purchase of
the land described
in the deed of
conveyance dated
10/10/1964 and
recorded in the
County of Los Angeles
Records, Book 10, Page 10.

Very truly yours,
[Signature]
[Name]
[Title]

00-03960

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11694
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADYS Amelia PLEASANT		2a. DATE OF DEATH MONTH DAY YEAR 04/11/86		2b. HOUR 6:50 A	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 02/16/11		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN PLEYSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5512 ROCKS ROAD 21132	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Hamilton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Etta Govans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-20-7681	17. INFORMANT ADDRESS Robert Pleasant Jr. same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/11/86 , 19 86 , to 4/11/86 , 19 86 , that (I) (we) last saw the deceased alive on 4/11/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph Reinhardt		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/15/1986	23c. NAME OF CEMETERY OR CREMATORY Jarretttsville Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Jarretttsville, Harford, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarretttsville, Md.		25. DATE REC'D. BY REGISTRAR APR 16 1986			

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0-04339

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) NORMAN JOE Powers					2a. DATE OF DEATH MONTH DAY YEAR April 16 1986		2b. HOUR 12:55 PM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR January 31, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
11. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. STATE Md.					13b. CITY OR TOWN Port Deposit		13c. STREET ADDRESS / ZIP CODE 21904		
14. FATHER'S NAME FIRST MIDDLE LAST Saul Powers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clyde Hart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 216-30-9086		17. INFORMANT ADDRESS Port Deposit, Md 21904		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) EXTENSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-16 , 19 86 , to 4-16 , 19 86 , that (I) (we) last saw the deceased alive on 4-16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dante U. Monakic					DEGREE M.D.		22c. DATE SIGNED 4/16/86		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Harold Grace, MD					23b. ADDRESS 21078 DANTE U. MONAKIC, M.D.				
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE April 19, 1986		23e. NAME OF CEMETERY OR CREMATORY Harmony Chapel Cem.		23f. LOCATION CITY OR TOWN COUNTY STATE Liberty Grove Cecil Md.			
24. FUNERAL DIRECTOR Lee A. Patterson & Son					ADDRESS 21903 Perryville, Md.		25a. DATE REGD. BY REGISTRAR APR 22 1986		
25b. REGISTRAR'S SIGNATURE Lee A. Patterson & Son									

BP

88810-2

20% COTTON FIBER

WASH-314-1

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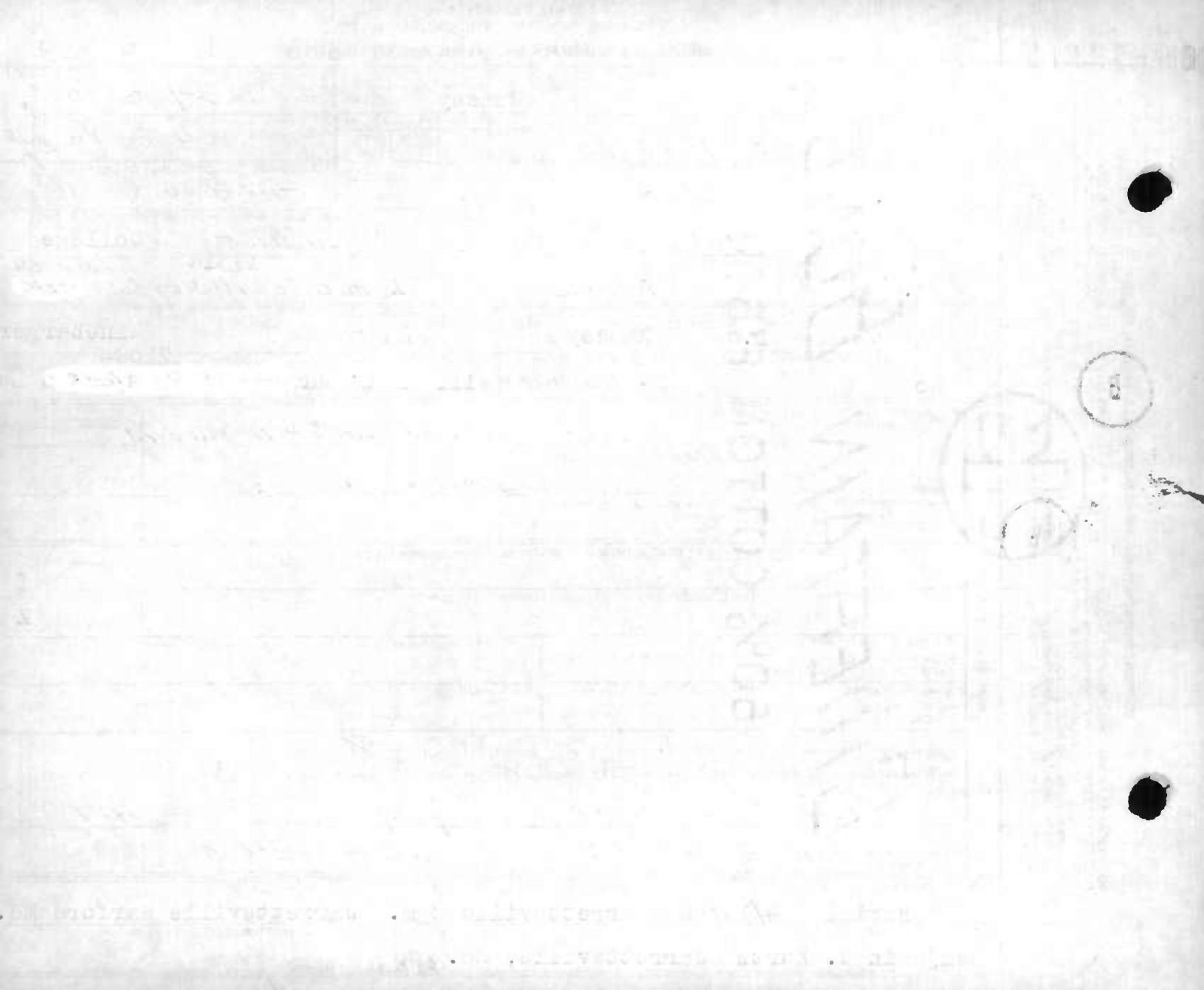
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGES 4 AND 5. THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Scott</i>		MIDDLE <i>Thomas</i>		LAST <i>Ramsey</i>		2a. DATE KNOWN OF DEATH		ESTIMATED <input type="checkbox"/> 4 6 86 <input checked="" type="checkbox"/> 4 6 19		2b. HOUR 3 p.m.	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 7 66</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>20</i> YRS.		IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>		IF UNDER 24 HRS HOURS MIN. <i>0 0</i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>4 6 86</i>		2d. HOUR <i>6:10</i> p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>					
10. CITY OR TOWN OF DEATH <i>Jarrettsville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3605 Anderson Ln</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Student</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>College</i>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>Pa.</i>		13b. COUNTY <i>York</i>		13c. CITY OR TOWN <i>Delta</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>17314 Capetown Rd. 1012 Court Meyler</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>William L. Ramsey</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Tanet Winebarger</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-02-4406</i>		17. INFORMANT ADDRESS <i>William L. Ramsey 3605 Anderson Ln</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>self inflicted bullet to head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>repression</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Luis E Rangel</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>4-6-86</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E Rangel</i>		ADDRESS <i>464 Alliance St</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/10/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Jarrettsville Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Jarrettsville Harford Md</i>							
24. FUNERAL DIRECTOR NAME ADDRESS <i>Benjamin W. Kurtz Jarrettsville, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 0 1986</i>		25b. REGISTRAR'S SIGNATURE <i>L. E. Rangel</i>							



0-05034

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8611697
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hayward Charles Richardson			2a. DATE OF DEATH MONTH 4 DAY 18 YEAR 86			2b. HOUR 8 P.M.					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 12 DAY 14 YEAR 49		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.					
10. CITY OR TOWN OF DEATH Pylesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1506 Harkins Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal worker		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Hartford		13c. CITY OR TOWN Pylesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1506 Harkins Road Pylesville Md 21152			
14. FATHER'S NAME FIRST Hayward MIDDLE Charles LAST Richardson						15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Jane LAST Whiteford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-52-5784		17. INFORMANT ADDRESS Physician - B.F. Polk - see below							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) Immune deficiency		2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent infection		4 years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from June 11, 1985 to April 18, 1986 , that (1) we last saw the deceased alive on March 11, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. Frank Polk		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. FRANK POLK		22e. ADDRESS 615 N. Wolfe St., Baltimore MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-21-86		23c. NAME OF CEMETERY OR CREMATORY FANN GROVE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE FANN GROVE YORK PA	
24. FUNERAL DIRECTOR NAME JOHN HARKINS 600 MAIN ST. DELTA, PA				25. DATE REC'D. BY REGISTRAR APR 23 1986			

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00-02447

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

11598

1. DECEASED NAME FIRST MIDDLE LAST WAYNE EDWARD SALISBURY			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1986		2b. HOUR 8:40 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1940		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (EXPECT WORK FOR MOST OF WORKING LIFE) Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Ceramics	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Bernard Salisbury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith E. Watchman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-40-9928	
17. INFORMANT ADDRESS Bel Air, Md. 21014		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from Jan 5 , 19 76 , to April 1 , 19 86 , that (I) (we) last saw the deceased alive on 2/3/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Anna Xena		DEGREE M. D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/86	
22d. PRINT NAME (TYPE OR PRINT) ANAKAWA M.O.		22e. ADDRESS 318 The Union Ave. Newde Grace Md. 21098					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Apr. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.	
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR APR 03 1986		25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0-02942

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 11699

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
MADELINE V. SEIDOMRIDGE					April 4, '86	11:15 AM
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE	DEC. 24 1904		81 YRS		
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA	U.S.A.			Harford Co. MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Fallston	Fallston General Hosp		HOMEMAKER		-	
13a RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		
MD. BALTIMORE	KINGSVILLE			900 MONICA CIRCLE 21087		
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
CHARLES PAGE		ALICE BOYD				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17. INFORMANT ADDRESS				
NO	214-18-5596	JUNE MYERS (DGHTR) SAME ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>Probable Acute Myocardial Infarction and/or CVA (stroke)</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Severe asthma, ischemic heart disease, Angina</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11:15 AM</u> X yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Chronic Respiratory failure, Carcinoma of Colon at Cecum</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c AUTOPSY?		19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
April 15, '86		Carcinoma of Colon at Cecum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, ANSWER MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)		
N/A		N/A		N/A		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
N/A		N/A		N/A		
22a I certify that (I am this hospital) attended the deceased from saw the deceased alive on <u>April 4, 1986</u> and that (I/we) did not view the body after death. and that (my/our) opinion death occurred on the date and hour and from the causes stated above.						
22b SIGNATURE		DEGREE		DATE SIGNED		
<u>Albert S.C. Sun, M.D.</u>		<u>(Medical) Surgeon: Dr. Qureshi</u>		<u>4/4/86</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
<u>Albert S.C. Sun, M.D.</u>		<u>1800 Harford Rd. Fallston, MD</u>		<u>21047</u>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		4/7/86	BALTO. NAT'L		BALTIMORE MD.	
24 FUNERAL HOME NAME		24b ADDRESS		25a DATE RECORDED		25b REGISTRAR'S SIGNATURE
SCHIMUNEK FUNERAL HOME, INC.		9705 Belair Rd., Balto. Md. 21236		APR 8 1986		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

10/11/80 18



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11700
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice M. Sinclair			2a. DATE OF DEATH MONTH DAY YEAR April 4, 1986			2b. HOUR 1:05 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 29 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grace Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry Service		12b. KIND OF BUSINESS OR INDUSTRY V.A.M.C.	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. IN SIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 625 Richmond Street 21903	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Bird			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melinda Barrow			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-05-4145			17. INFORMANT ADDRESS 421 Broad Street James W. Thompson, Jr., Perryville, Md. 21903						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Jan 1975 to April 4 1986 that (I) (we) last saw the deceased alive on April 4 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Yun			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE 4/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN			22e. ADDRESS Home de Grace, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 7, 1986		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson Son Perryville, Maryland			25a. DATE REC'D. BY REGISTRAR APR 07 1986		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

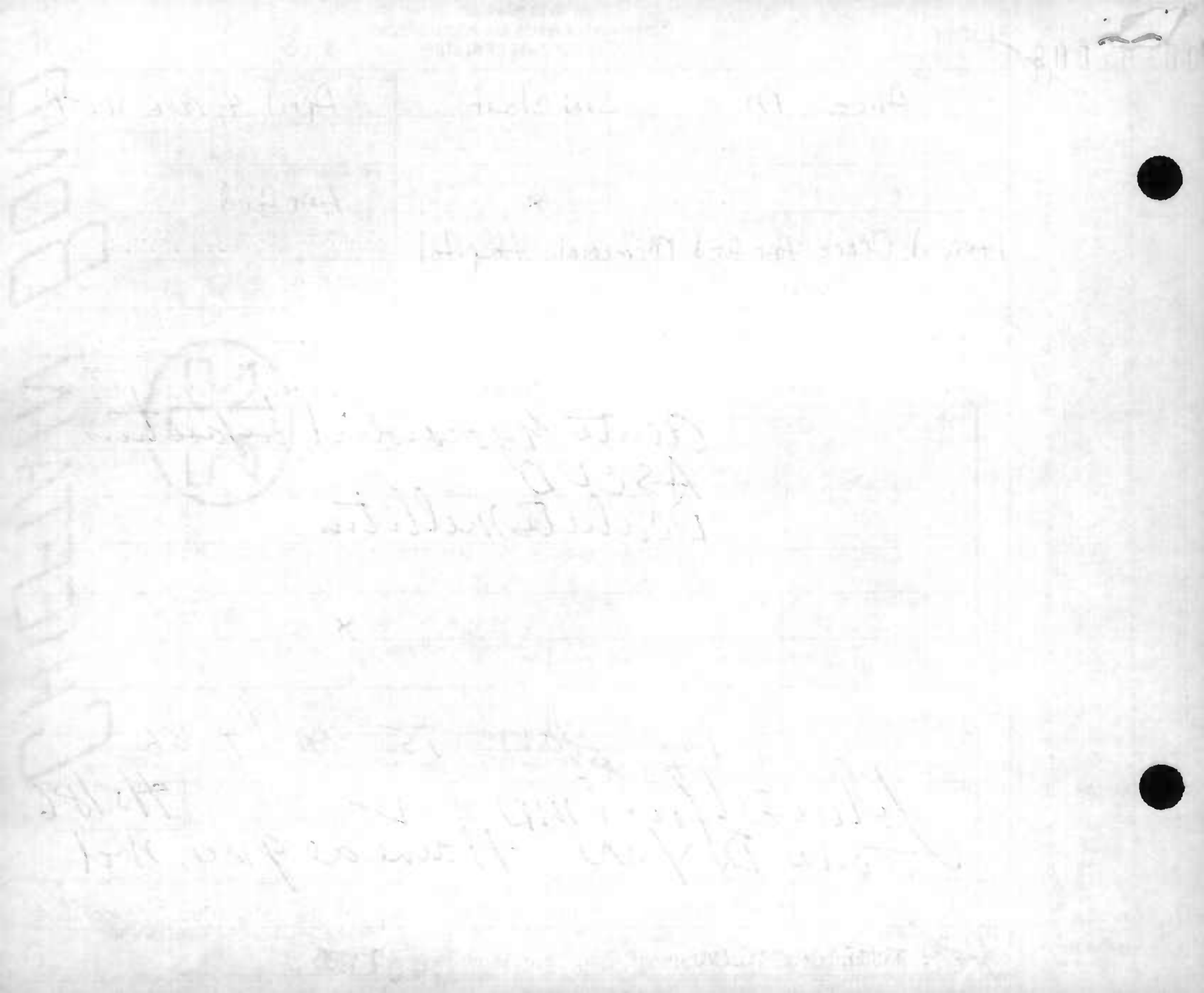
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-04106

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11701

1. DECEASED NAME (TYPE OR PRINT) VERNON F. Smith			2a. DATE OF DEATH MONTH DAY YEAR April 13, 1986			2b. HOUR 1 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 15 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY Transportation	
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Curtis E. Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Diffendarfer			13e. STREET ADDRESS / ZIP CODE 2921 Guyton Rd., 21047			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 216-10-8894		17. INFORMANT ADDRESS Elmer V. Smith, 2921 Guyton Rd., Fallston, Md					
18. CAUSE OF DEATH (Enter only one cause per line prior to (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL DEATH DUE TO, OR AS A CONSEQUENCE OF STROKE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF HYPERTENSIVE ARTERIOSCLEROTIC DISEASE (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-20, 1986, to 4-13, 1986, that (I) (we) last saw the deceased alive on 4-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL					22c. ADDRESS Havre de Grace, Md 21078		22e. DATE SIGNED 4/13/86		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial Southern			23b. DATE April 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Dublin Southern		23d. LOCATION CITY OR TOWN COUNTY STATE Dublin Harford Md.		
24. FUNERAL DIRECTOR NAME John H. Harkins					25a. DATE REC'D. BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall		

MEDICAL CERTIFICATION

29

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card (page 4) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-04210

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11702
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY ALEXANDER SONBERG			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1986		2b. HOUR 10:03 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 28, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Abingdon, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Abingdon		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1314 Abingdon Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmaster		12b. KIND OF BUSINESS OR INDUSTRY US Postal Service		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY, OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles James Sonberg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pouska			16. SOCIAL SECURITY NO. 212-12-5969			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			17b. SOCIAL SECURITY NO. 212-12-5969			17. INFORMANT ADDRESS Md. 21009 Lillian Sonberg, 1314 Abingdon Road, Abingdon			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA, BRONCHITIS WITH DUE TO, OR AS A CONSEQUENCE OF CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) ADENOCARCINOMA OF LUNG WITH METASTASES BRAIN								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 9, 1960 to APR 17, 1986 that (I) (we) last saw the deceased alive on APRIL 17, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Philip W. Heuman</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 4-18-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip W. Heuman, M.D.						22e. ADDRESS 307 Hickory Ave., Bel Air, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Cokesbury U.M. Cemetery, Abingdon Harford Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

2025 COLLECTION 412248

WINTERBURY

00-05023

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner must be notified of.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 11703

1. DECEASED NAME (TYPE OR PRINT) DELLA EMALINE SPARKS			2a. DATE OF DEATH MONTH DAY YEAR 4/21/86		2b. HOUR 7:15P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 12 98		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston (21047)	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air (21014)	13d. STREET ADDRESS / ZIP CODE 224 EASTERN AVENUE 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Silas Morrison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINERVA CROOKSHANK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-12-8766 F2		17. INFORMANT (SON) 838-3351 MR. KENNETH F. SPARKS	
				ADDRESS 106 Woodland Drive Bel Air, Maryland 21014	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Card arrest DUE TO, OR AS A CONSEQUENCE OF (b) End stage COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. COPD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) COPD, Cor. retention.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/15 1986	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital attended the deceased from 4/15 1986 to 4/21 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) visit the body after death.			
22b. SIGNATURE [Signature]		22c. DATE SIGNED 4-21-86	
22d. PHYSICIAN'S NAME V.S. MAR 2 M.D.		22e. ADDRESS 2112 Bel Air Road, Fallsh. MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 24, 1986	23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR, Harford Co., Maryland 21014
24. FUNERAL DIRECTOR JOSEPH WILLIAM FOSTER Superior Funeral		25a. DATE REC'D. BY REGISTRAR APR 23 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell

00-03339

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11704
REG. NO.FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Winifred</u> MIDDLE <u>Augusta</u> LAST <u>Spies</u> <u>Winifred Augusta Spies</u>		2a. DATE OF DEATH MONTH <u>4</u> DAY <u>9</u> YEAR <u>86</u>		2b. HOUR <u>12</u> ⁴⁵ _P M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>2</u> DAY <u>24</u> YEAR <u>14</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Connecticut</u>		8. IF UNDER 1 YEAR MONTHS <u>7</u> DAYS <u>1</u>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.		10. CITY OR TOWN OF DEATH <u>Fallston</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hospital</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		13a. STREET ADDRESS / ZIP CODE <u>3901 Philadelphia Road</u> <u>21009</u>	
14. FATHER'S NAME FIRST <u>Thomas</u> MIDDLE <u>Carter</u> LAST <u>Morgan</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Augusta</u> MIDDLE <u>Florence</u> LAST <u>Rosier</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>	
16b. SOCIAL SECURITY NO. <u>213-05-8155</u>		17. INFORMANT ADDRESS <u>Abingdon, Md. 21009</u> <u>Frederick J. Spies, 3901 Philadelphia Road</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>					
19a. DATE OF OPERATION <u>4/9/86</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHF</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/86</u> , 19 <u>86</u> , to <u>4/9/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/9/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. S. Spies</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. S. Spies</u>		22e. ADDRESS <u>Abingdon, Md. 21009</u>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>April 12, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air Harford Md.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Abingdon Harford Md.</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>Howard K. McComas III, Abingdon, Md. 21009</u>		25a. DIED BY REGISTRAR <input checked="" type="checkbox"/> 25b. REGISTRAR'S SIGNATURE <u>W. S. Spies</u>	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-04338

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11705
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) G Bart Stone		2a. DATE OF DEATH MONTH DAY YEAR April 20 1986		2b. HOUR 3:49 P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1920	
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (PE OF WORK FOR MOST OF WORKING LIFE) Psychologist	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Harre de Grace	
14. FATHER'S NAME FIRST MIDDLE LAST Gideon Barto Stone		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bess Keller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) Yes (IF YES, GIVE YEAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 186-16-6595		17. INFORMANT ADDRESS Nancy J. Stone, 2 Chesapeake Dr., Harre de Grace Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 4-22 1984 to 4-20 1986 , that (I) (we) last saw the deceased alive on 4-20 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (I did not) view the body after death.					
22b. SIGNATURE GUNTER HIRSCH		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 4-20-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUNTER HIRSCH		22e. ADDRESS 131. S. UNION AV. HARRE DE GRACE Md.			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE April 23, 1986		23c. NAME OF CEMETERY OR CREMATORY R. A. Ferris & Co	
23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, West Goshen, Pa.		25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE Lee A. Patterson & Son, Perryville, Maryland.	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		86 REG. NO.		11706					
1. DECEASED NAME (TYPE OR PRINT) <i>Olive Cathleen Thomas</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>4 7 86</i>		2b. HOUR <i>5 A M</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 28 00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.			
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Harre de Grace</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4413 Webster Lapidum Rd. 21078</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alonzo Beaver</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minerva J. Swiger</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT ADDRESS <i>B.L. Thomas, 4413 Webster-Lapidum Rd., H de G., MD 21078</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>LUNG CANCER</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>DIABETES</i> (c) <i>CHRONIC DEBILITATION</i>								<i>Years</i> <i>2 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19 86</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>3/5</i> , 19 <i>86</i> , to <i>4/7</i> , 19 <i>86</i> , that (1) (we) last saw the deceased alive on <i>4/5</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Phillips</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/7/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. PHILLIPS</i>				22e. ADDRESS <i>2005 Rock Spring Rd. Forest Hill</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Apr. 10, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</i>				25a. DATE REC'D BY REGISTRAR <i>APR 09 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randall</i>			

20% COTTON FIBER

CHIEFMAN FUND



00-05481

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11707

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie Hess Tipton			2a. DATE OF DEATH MONTH DAY YEAR April 26, 1986		2b. HOUR 1:00A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3754 Federal Hill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hess		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Evans Ball		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-76-1088	
17. INFORMANT ADDRESS John M. Tipton Sr. Jarrettsville							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Recurrent Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Severe Dementia, Parkinson's Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **5/24**, 19 **81**, to **4/25**, 19 **86**, that (I) (we) lost
saw the deceased alive on **4/21**, 19 **86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

MDATTENDING
PHYSICIANMEDICAL
DIRECTOR ☒STAFF
PHYSICIAN ☐

22c. DATE SIGNED

4/26/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Randall C. Cronin, Jr., M.D.**721 Wheeler School Rd. Whiteford, Md.**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) **Burial**23b. DATE
4/28/198623c. NAME OF CEMETERY OR CREMATORY
Jarrettsville Cem.23d. LOCATION
CITY OR TOWN COUNTY STATE**Jarrettsville, Harford, Md.**

24. FUNERAL DIRECTOR

NAME

ADDRESS

M. Gladden Kurtz**Jarrettsville, Md.**

25. DATE RECEIVED BY REGISTRAR

MAY 01 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

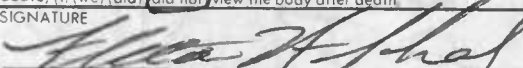
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN			MIDDLE S.			LAST TYLEE			2a. DATE OF DEATH MONTH DAY YEAR			7b. HOUR 5:20			A M
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 4 1 28			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.									
10. CITY OR TOWN OF DEATH Joppa			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 33 Neptune Dr.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Joppa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 33 Neptune Drive 21234						
14. FATHER'S NAME FIRST MIDDLE LAST Don O. Tylee									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Falkenstein									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 188-20-3359						17. INFORMANT ADDRESS Mrs. Jeanne Tylee Same as #13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 9, 1985</u> to <u>April 20, 1986</u> , that (I) (we) last saw the deceased alive on <u>April 8, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Flota H Sokal MD				22e. ADDRESS 636 Towne Center Dr Suite 202			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 4-21-86	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.	25a. DATE REC'D. BY REGISTRAR APR 29 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>		

DIVISION OF VITAL RECORDS, 20 NEW PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH-16 50M 1/B1
(VRA 15.4)

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JAN 24 1962



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JAN 24 1962

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11709
REG. NO.1- FOR
STATE 5/28/86 rja
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph Alois Vachek			2a. DATE OF DEATH MONTH DAY YEAR April 5 1986		2b. HOUR 9:50^A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1904		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr. Machine Shop		12b. KIND OF BUSINESS OR INDUSTRY Shoe		13. STREET ADDRESS / ZIP CODE 21009		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		
14. FATHER'S NAME FIRST MIDDLE LAST Alois -- Vachek		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia -- Stastny		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 215-38-3140		17. INFORMANT Mrs. Beatrice Vachek, 905 Philadelphia Ave		18. ADDRESS Abingdon, Md. 21009		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **uremia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **nephrosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 months**> 5 YRS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

alzheimer's disease, arteriosclerotic heart disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from March 31 , 19 86 , to April 5 , 19 86 , that (I) we lost saw the deceased alive on April 5 , 19 86 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did not) view the body after death.							
22b. SIGNATURE B. J. Plimbert				DEGREE MD		22c. DATE SIGNED April 6, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 6, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE W. Chester Chester Pa.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR APR 08 1986			
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

ADDITIONAL LINES

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00-05181

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 7 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Catherine M. Mae Welsh</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>April 28 1986</i>		2b. HOUR <i>9:45</i> M	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 24, 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Aberdeen</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry --- Sheridan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hattie --- Mahan</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>212-34-6577</i>		17. INFORMANT ADDRESS <i>Charles T. Welsh, 2030 W. Park Beach Drive Aberdeen, Md. 21001</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Carcinoma of lung*

DUE TO, OR AS A CONSEQUENCE OF

(b) *---*

DUE TO, OR AS A CONSEQUENCE OF

(c) *---*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

peripheral vascular disease, arteriosclerotic heart disease, rheumatoid arthritis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4-28 1986</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>4-28 1986</i> to <i>4-28 1986</i> , that (I) (we) lost saw the deceased alive on <i>4-28 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. J. Plunkett Jr M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4-28-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>April 30, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. George's Episcopal Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Perryman Harford Md.</i>
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>		25. DATE REC'D. BY REGISTRAR <i>APR 30 1986</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

04442

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 11711		
1. DECEASED NAME (TYPE OR PRINT) Charlotte C. Wisel					2a. DATE OF DEATH MONTH DAY YEAR 4 15 86					2b. HOUR 4:30P.M.		
3. SEX Female		4. RACE CAUCASIAN XXXXXXXXXX		5. DATE OF BIRTH MONTH DAY YEAR 3 25 1898			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford COUNTY MD.						
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Hartford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 502 BEECHCROFT RD. 21047				
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 215-38-1762				17. INFORMANT ADDRESS 21047 WILLIAM W. WISEL 502 BEECHCROFT RD. FALLSTON, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS, combined GRAM ⁺ and ⁺ DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, CVA's, Chronic renal insufficiency												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 1/26/82, 19____, to 04/15/86, 19____, that (I) (we) last saw the deceased alive on 04/14/86, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b. SIGNATURE David R. Padrino				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 04/15/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. PADRINO				22e. ADDRESS 1212 Churchville Rd. Bel Air, 21014								
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL		23b. DATE 4/18/86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEM		23d. LOCATION BALTIMORE MARYLAND STATE						
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215						25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRAR'S SIGNATURE H. H. Anderson				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Dr. Friedrich Lammert, 1910

Dr. Friedrich Lammert, 1910

Dr. Friedrich Lammert

x

Dr. Friedrich Lammert, 1910

Dr. Friedrich Lammert

Dr. Friedrich Lammert

0-03222

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBY K. WOOD						2a. DATE OF DEATH MONTH DAY YEAR April 6, 1986		2b. HOUR 11:14 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 28, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Horse de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) FARMER		12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 602 WALKER STREET 21001	
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 07 1975		17. INFORMANT ADDRESS MR. RAYMOND WOOD 440 FRANKLIN ST. BEL AIR, MD. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Severe Dehydration; Severe Hyperthermia; Pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/2/86</u> 19 <u>86</u> to <u>4/6</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. de la Santes						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. de la Santes						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10 Apr. 86		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Md.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE	

NEW YORK

NOV 10 1955

MINNEAPOLIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 1 1 7 1 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Marion</u> MIDDLE <u>Ellen</u> LAST <u>Young</u>		2a. DATE OF DEATH MONTH <u>4</u> DAY <u>11</u> YEAR <u>86</u>		2b. HOUR <u>8³⁰</u> P.M.	
3. SEX <u>F</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH <u>June</u> DAY <u>29</u> YEAR <u>1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pleasant Gap, Pa.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Bel Air</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Belair Convalescent Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Waitress</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. CITY OR TOWN <u>Harford</u> 13c. CITY OR TOWN <u>Forest Hill</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>21050</u> <u>109 Marshall Drive, Forest Hill, Md.</u>	
14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Henry</u> LAST <u>Knoffsinger</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Cora</u> MIDDLE <u>Ellen</u> LAST <u>Myers</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>195-16-5556</u>		17. INFORMANT ADDRESS <u>Forest Hill, Md. 21050</u> <u>Mrs. Shirley E. Neff, 109 Marshall Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Colon with Widespread Lymph Node Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease; Liver Failure Anemia</u>					
19a. DATE OF OPERATION <u>1/28/86</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Advanced Cancer of Colon</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>AM</u> MONTH <u>19</u> DAY <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 85</u> to <u>4/10 86</u> that (I) (we) last saw the deceased alive on <u>4/10 86</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Willard P. Amoss</u>		DEGREE _____		22c. DATE SIGNED <u>4/12/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Willard P. Amoss</u>		22e. ADDRESS <u>2303 Bel Air Rd, Fallston, Md 21047</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>April 15, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
23d. LOCATION CITY OR TOWN <u>Bellefonte</u> COUNTY <u>Centre</u> STATE <u>Pa.</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 14 1986</u>			
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u> ADDRESS <u>Abingdon, Md. 21009</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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